Wisconsin Medical Journal

V. 90 N. 1

Official Publication of the State Medical Society of Wisconsin

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January 1991

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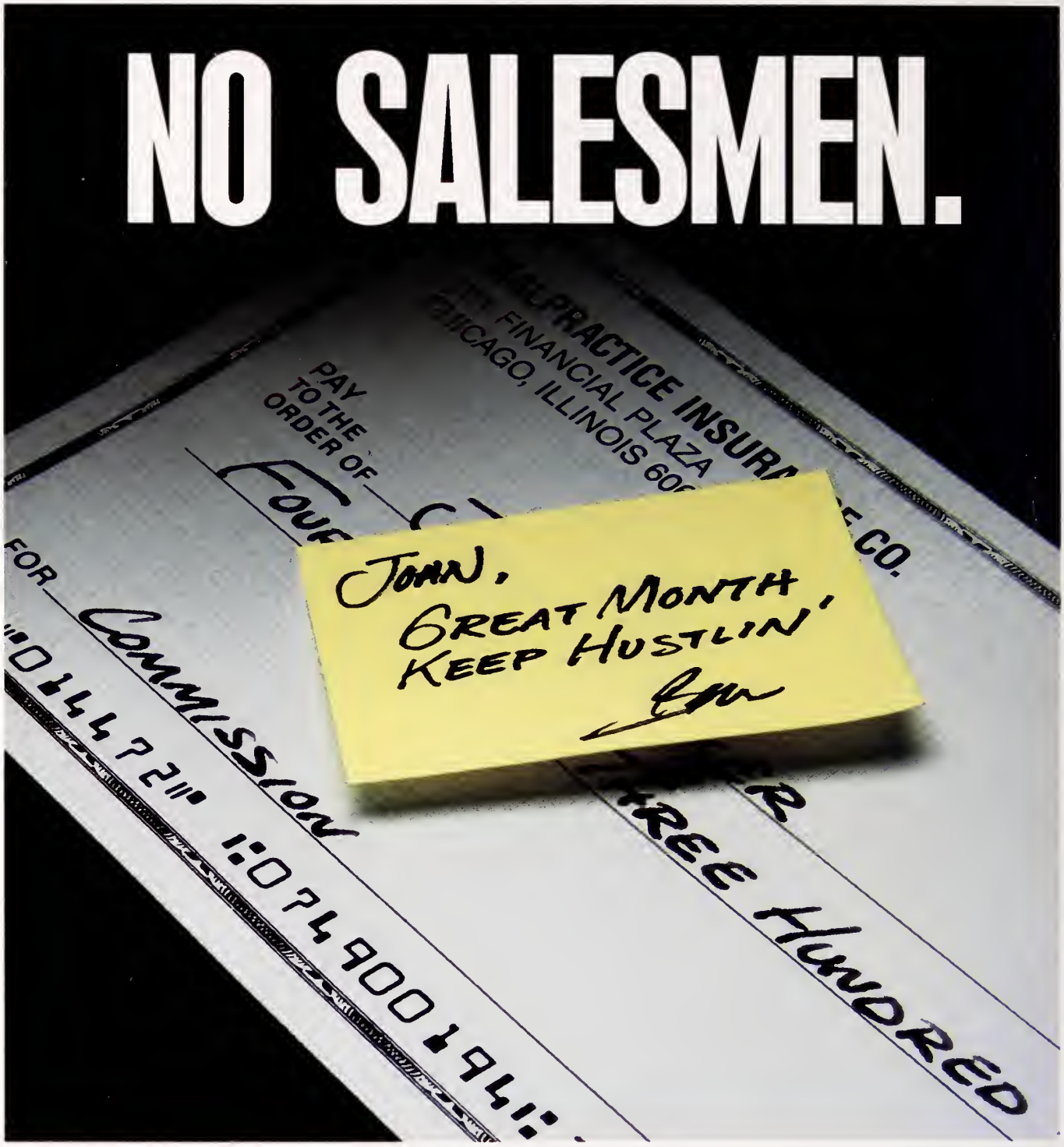

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Contents

January 1991 **Vol. 90 No. 1**

Opinions

3 *Secretary's report*
Answering the call for quality
by Thomas L. Adams, CAE, Madison

Editorials
4 O Doktor, Doktor
by Richard D. Sautter, MD, medical editor, Marshfield
4 Hospital mortality
by Richard D. Sautter, MD, medical editor, Marshfield

Letters
6 Physicians v machines
by William B.A.J. Bauer, MD, Ladysmith
8 An apology
by Chris Ecos, Waukesha
10 Editorial wins praise
by Morrison Schroeder, MD, Shorewood
10 Editorial draws fire
by Mark R. Aschliman, MD, Milwaukee
10 Applause for PartnerCare
by Vinoo Cameron, MD, Athens

12 *Special*
Surviing continuing medical education: A self-help manual for CME directors
by James S. Goodwin, MD, Milwaukee

Scientific

15 Percutaneous balloon pulmonary valvuloplasty in children
by Michael C. Zacharisen, MD, and David Z. Friedberg, MD, Milwaukee
19 The smoking cessation process
by Mary E. Wierenga, RN, PhD, Milwaukee
23 Mortality and morbidity in Wisconsin hospitals
by Vernon B. Hunt, MD, Madison

Socioeconomic

27 Observations on Wisconsin's public health agenda
31 *Public health*
Childhood lead exposure in Wisconsin in 1990
by Joseph Schirmer, MS, Henry Anderson, MD, and Dan E. Peterson, MD, Madison

Organizational

37 Physician briefs
38 County society news
39 Obituaries
41 Instructions to authors

Our cover: "Cardiology," by Aaron Bohrod, from the collection of the SMS Charitable, Educational and Scientific Foundation. The man in the painting is William Harvey, who first described the circulation of blood. Other elements of the painting include: a diagram of blood vessels, a model of an open heart, a stethescope, an electrocardiogram tracing and the flower, purple fox glove, from which digitalis is derived.

Wisconsin Medical Journal

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Secretary's report

Answering the call for quality

THE CHORUS OF VOICES calling for "quality" has risen from every corner of America–from our classrooms to our boardrooms–and continues to grow in its crescendo. Quality assurance, quality education, total quality management, quality products, continuous quality improvement: All of this talk is good, but it is only a first step. The next step is to define what we mean by quality and determine how we measure it. If the second step never comes, the talk is all just hot air; if the second step is in another direction, it will be over the edge and into an inescapable pit of bureaucratic quicksand. All of which is particularly true when we speak of "quality" in health care.

The new concern with quality in America is actually old news to medicine. I can think of no profession that has been more concerned with the quality of its training, the quality of its practitioners, or the quality of its "product." Nor can I think of any other profession that has had its quality so closely scrutinized, so vigorously debated, or so thoroughly regulated. Given that the level of quality in the profession can mean the difference between life and death, it's only natural that physicians–and the public–would have a strong interest in keeping that level high and climbing.

We know that we have served, and are continuing to serve, that interest. The development of practice parameters has been a major example of medicine's continued efforts at quality control and enhancement. In 1980, only eight physician organizations had practice parameters; today more than 30 specialty societies have developed more than 700 practice parameters and at least another 125 are in development. Physician leadership in the creation of practice parameters, as with all health care quality control measures, is essential, for these measures must be based on valid research, sound conclusions and the true experiences of practicing physicians. Were non-physicians to design these measures, they would run the risk of designing them on misconceptions or, even worse, utopian ideals of what medicine "ought to be" rather than what medicine really is.

Beyond the creation of quality standards lies the challenge of devising methods of conveying the quality of America's health care to the public in ways that it will understand. In fact, for the health of the profession, this may be the more important task. For instance, my counterpart at the Wisconsin Manufacturers and Commerce, Jim Haney, wrote in a recent letter to WMC members that, while there is increasing talk of trying a "Canadian" health care system, "We are not yet ready to throw in the towel on our current health care delivery system. But the need for more information about health care cost *and quality* is immediate and critical....

Thomas L. Adams, CAE

Purchasers of health care services need to apply the same kind of quality and cost analyses to health care vendors as they do to other vendors of goods and services."

While the reduction of the sacred physician-patient bond and the intimacy of the physician-patient interaction to a purchaser-vendor exchange of goods and services is an offensive notion (and one of the culprits in reduced patient satisfaction with health care), the call for clear, useable information on the quality of health care is as appropriate as it is direct.

The physicians of Wisconsin are at the forefront of the effort to provide that information. We have supported

Continued on next page

Continued from preceding page
the Office of Health Care Information from the time it was nothing more than a good idea, and our current SMS president, Roger von Heimburg, MD, sits on the OHCI board. More recent efforts include the creation of an SMS Task Force on Quality Assessment and Implementation of Practice Parameters, which is being formed this month. The task force will study and report on the issue of quality health care in general, but it will focus more specifically on determining the best ways to measure quality. Do we want to use computer models? Or, perhaps, standards based on review of hospital charts? The possibilities are limited only by our imaginations. What actuality eventually emerges from the possibilities must be shaped by the profession–and not by government, insurers, industry, or so-called consumer advocates.

The voice of America that is calling for quality in health care is calling to the entire profession, and if the profession does not answer, others will answer for it. So, once again, your involvement is essential. As John Donne so eloquently instructed us: "Every man is a piece of the continent, a part of the main ... therefore never send to know for whom the bell tolls; it tolls for thee."❑

Editorials

O Doktor, Doktor

THE REACTION OF Wisconsin physicians to the recent fake summons advertising the seminar examining malpractice issues was quite unfortunate. It has given some solace to our enemies.

It may be in poor taste, but it certainly did what advertising is supposed to do, it got our attention.

Imagine, however, the glee and gloating of the trial lawyers serving our anxiety attack, by receiving merely a fake summons. This reduced some to a quivering semi-gelatinous mass. Instead of a sigh of relief to discover it was fake, some rose in righteous indignation to smote the purveyor, who it appears was attempting to further our education to prevent the real thing.

Were I a trial lawyer, I would question if it were a guilty conscience that triggered such a response.

We have the right to be concerned about malpractice and about trial lawyers. But let's direct our concerns appropriately and welcome the offers to an educational experience to avoid malpractice.

To me this is a classic example of killing the messenger. (See also the letters section of this issue of *WMJ*.)

–Richard D. Sautter, MD
medical editor
Marshfield ❑

Hospital mortality

ON PAGE 23 OF THIS ISSUE of the *Wisconsin Medical Journal*, you will find an article by Vernon Hunt, MD, on the release of hospital mortality statistics in Wisconsin. The government, which released the mortality percentages of specifically identified hospitals, did the public, the nation's hospitals, and the medical profession a great disservice. The deficiencies, the discrepancies, and the illogical conclusions reached from these data are too numerous to mention.

What has been consistently overlooked, however, is that after considering the prognosis of a patient's specific disease entity, the single most relevant and important variable in hospital mortality is the quality of the hospital staff. The single most critical variable in the hospital staff is the quality of the physicians.

People don't die under the care of hospitals, they may die in hospitals, but under the care of specific physicians and nurses. These reports are not the evaluation of hospitals, but the staff of those hospitals.

Praise from the consumer advocate groups for the government's release of this information indicates these groups have little, if any, concept of the practice of medicine or what is quality care. It's important that the patients understand that

Continued on page 6

Where there's smoke...there may be bronchitis

"Recent research has delineated early, more subtle changes in lung and immune functions. These alterations directly predispose smokers to respiratory tract infection."

Am Fam Phys 1987;36:133-140

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Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of non-susceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
• Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Continued from page 4
hospital mortality percentages quoted from whatever source, are the accumulated mortality of all physicians on the staff whose specialties may range from dermatology to oncology, which have widely variable mortality rates.

It's frightening to anticipate patient's selecting a hospital based on mortality percentages. What is even more frightening, is for patients to select a physician based solely on mortality statistics. Patients should primarily be concerned about their physician's qualifications and what kind of care he or she provides them.

Whether a seriously ill patient will survive depends primarily on with what illness the patient has and the quality of the care delivered. To mislead the public regarding what hospital to enter, looking only at the mortality percentages of an institution, is cruel, deceptive, and absurd.

There can be no meaningful doctor-patient relationship without trust. My advice to patients is that if you don't trust your current physician, find one you do trust and accept his or her advice, including on the question of where to be hospitalized.

–Richard D. Sautter, MD
medical editor
Marshfield ❑

Letters
Physicians v machines

To the editor: Machines are trying to replace doctors as they have replaced humans in many assembly lines. While some of these may save time and effort, total replacement of the physician can never be totally successful. There are countless situations in which a machine can test the efficiency of the lungs, heart, kidneys, liver, and blood, but there are countless situations in which a machine can not test the efficiency of the human spirit. The touch of the experienced and kindly hand will ever be essential.

Unfortunately, we have so fallen into the dominant grasp of financial success that we gear our businesses and professions, not by quality, but by quantity performance. By doing so, our profession has lost a great deal of its warm patient-doctor relationship.

Some physicians have lost an awareness of their genuine goal–the total health of their patient, and that total health includes the interrelationship of the patient's mental, emotional, and physical condition. Rarely does a patient pass through any doctor's office who is not in need of the doctor's warm touch. How and what a doctor says is relevant to the patient's recovery, even in the most subtle way. A woman with breast cancer can be told that three out of five cases died in less than five years or that two out of five survive five years.

The more we become aware of our responsibility, the more we recognize the depth of that responsibility. For example, there are times when we strongly desire to assure our heart patients of their need to follow a definite routine. In doing so we can, and often do, scare our patients into a state of stress, where their every waking moment is spent asking themselves or others: "Am I eating correctly? Am I getting enough exercise? Do I need aerobics? Am I losing enough weight? How is my cholesterol?"

Today, an obsession with one's physical condition has become rampant. Certainly, it behooves all of us

Continued on page 8

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

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First Choice of Wisconsin Physicians

Continued from page 6
to be aware of those factors that are harmful to our health, that limit our activities and shorten our lives...alcohol, drugs, tobacco, overeating as well as eating the wrong foods. Surely, those with a family history of heart disease, kidney disease, high blood pressure, gout, and diabetes should be especially careful. But, I believe an obsession with all these factors also can be harmful.

"How you doin', Charlie?" is a question often asked. The answer often heard signifies what I am suggesting. "Fine, I'm staying on my diet, but not having any fun." This is the human element. If we are not having fun and are constantly reminded that we are being deprived of simple pleasures, we are under stress. Doctors need to respond to the inner man's needs, but with moderation.

Stress comes in various packages...the stress of work, bills that need to be paid, sickness of family members, taxes, rent, and mortgage payments, to name a few. However, there are many stresses that go unrecognized. One of these is the stress of being constantly worried about one's physical condition. An obsession of this nature is a real hazard to one's health. I see many men and women with long faces, who talk and breathe diet and exercise and cholesterol tests almost to the exclusion of anything else. Driving a car cautiously is important. Driving a car in constant fear of all the elements that might cause a crash is hazardous.

Doctors can add to this obsession by the manner in which they approach their patients. "Listen Ben, you gotta quit smoking. No more going out with the boys. Those 'fast foods' joints are not for you. If you don't quit your job, eat right, stop smoking–I'm afraid it will be the end of you."

This is a difficult pill to swallow for any man or woman. We humans often need a firm opinion but we also need a soft understanding touch. "Ben, I've known you a long time. You have a heart of gold and a will like steel. If you decide to do something. You always manage to get it done. Your heart has carried you through a long life with many detours. It's tired. It needs a little coddling which means reducing some foods that strangle the arteries. Let the younger fellows take over your business. Keep your fingers in the pie as an overseer. Let the family get to see more of you and you of them. You have carried the ball all these years. Time you eased up. This shouldn't be too difficult for you. In fact, you may enjoy it. I know your family will approve and you will be around for a long time."

Yes, physicians can well be responsible for initiating the stress that comes from the anxiety over one's health. On the other hand, a physician can mitigate the stress–something a machine can't accomplish. This is one of the most important roles of a physician–to soothe the patient's inner man and help him to climb over the hurdles. It takes an experienced and kindly hand.

–William B. A. J. Bauer, MD
Ladysmith

Editor's note: The author is again reminding physicians of the art of medicine, but we must also not forget that the most important single thing we can do for a patient is to provide him or her with an accurate diagnosis.–RDS ❑

An apology

To the editor: Enclosed is a copy of the recent *Milwaukee Journal* article discussing my unfortunate attempt to invite physicians to a seminar with the "court summons." I have also attached a copy of the apology and explanation letter that I mailed 2 days after the original went out. Please review it and keep it with your file on this incident.

I have endured many phone calls from doctors, almost all *very* upset, letters, and the article in the paper. This has not worked out as expected and has not been very pleasant. However, I take full responsibility and understand why there has been this emotional reaction.

I have responded to each call and have contacted both the Milwaukee County Medical Society and the State Medical Society to make sure that you have seen the apology and know how much I am sorry for this.

Please contact me if you have any questions, or if there is anything that I can do.

–Chris Ecos
Waukesha

Editor's note: The letter of apology sent to physicians reads as follows.

Dear Doctor:

I want to apologize for the mailing that I sent you regarding Foreign Trusts. Although it was not illegal, I now realize that it can be viewed as extremely poor taste and that it may have been offensive to you and your profession. I completely misjudged the magnitude of the impact it could make to a practicing physician.

Mr Rudman of Engle and Rudman had nothing to do with the structure

Continued on page 10

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Continued from page 8
of the invitation. My partner and I (we are not attorneys) put it together through our small marketing company. Mr. Rudman was not aware of the special invitation that we sent out. He is now.

Malpractice is clearly a very sensitive issue in your profession. My purpose was for you to see a viable alternative to high premiums and to provide protection for your assets. Mr. Rudman is a credible source who has developed an expertise in this area of law. He has worked with an increasing number of doctors around the country to provide his specialized trust services. My idea was to encourage you to come out and learn about his concept.

Again, it is with the utmost sincerity that I say that I am sorry. I wanted to get your attention, but I did not intend to alienate you to the message. I regret it, if that was your reaction.

Sincerely, Chris Ecos
Security Conveyance Corp.❑

Editorial wins praise

To THE EDITOR: President von Heimburg's message, "We are humanitarians first" (*Wis Med J* 1990;89(11):619-620), is a forthright statement about one of the ills of our profession of which we are ashamed. I commend him for it.

Over many years on ethics and mediation committees, I have learned of many instances similar to those he cited, some even more outrageous.

Some greed is universal, but certain physicians are much greedier than most.

–Morrison Schroeder, MD
Shorewood❑

Editorial draws fire

To THE EDITOR: ...Regarding Dr von Heimburg and his recent editorial ("*President's page* We are humanitarians first" *Wis Med J* 1990;89(11):619-620):

If this is the stand of the State Medical Society, then I must seriously consider terminating our association. The AMA no longer represents the interests of many physicians and I am one of several who have, unfortunately, quit the association. While I am not eager to do so with the SMS, if need be, I will do so. This is not a threat, merely a statement of fact. I am not going to send a check to an organization that does not represent my interests. I hope Dr von Heimburg understands this.

–Mark R. Aschliman, MD
Milwaukee❑

Applause for PartnerCare

To THE EDITOR: The following is the text of a letter sent to Representative Brad Zweck of Mosinee.

I just want to share some thoughts with you regarding the PartnerCare program sponsored by the State Medical Society of Wisconsin. You were a sponsor of this and, as you well know, the last 10 years I have been talking to various legislators about the need for such a program. This program has helped a lot of individuals and I will just simply describe to you an instance that recently happened in my office.

Yesterday I had a trusting lady of 84 years come to my office, along with her daughters. About 5 or 6 years ago I had attended to her husband, who was diagnosed as having lung carcinoma. At that time the family did not have any PartnerCare.

When I examined the lady, I was astounded to note that she had extremely large total prolapse of the uterus, which was badly infected, and she also had a large parotid gland tumor, for which she never sought treatment. When the patient was advised to be admitted to the hospital, she at first refused and it turned out that when the husband was ill 4 or 5 years ago all their savings were used up in paying for the extra bills that Medicare did not cover.

Now, fortunately, this lady has PartnerCare and a supplemental policy from an insurance company and it did take some convincing to assure her that she would not have any extra bills this time. It also is very possible that she did not seek help for her current condition for a long time because of the fear of medical bills.

This is a true story, but I think there will be a happy ending because her uterine prolapse is going to be taken care of and I believe her parotid tumor is benign. I think the PartnerCare program has had a great impact and I thank you personally for being a party to such a program, along with the State Medical Society of Wisconsin.

–Vinoo Cameron, MD
Athens ❑

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Surviving continuing medical education: A self-help manual for CME directors

James S. Goodwin, MD, Milwaukee

OVER THE PAST SEVERAL YEARS there has been quite a bit written about how continuing medical education (CME) speakers can give more effective oral presentations. But what can local CME directors of do to enhance a presentation? A lot. The following are my suggestions for CME directors. Following them will not transform a turkey of a speaker into a swan, but it will give the mallards among us a better chance to succeed. And if we succeed, everyone is better off than if we fail.

First, learn enough about the speakers to give them a good introduction. In other words, read the curriculum vitae. If a speaker has performed research, published in good journals, or otherwise has impressive academic credentials, mention them. A good introduction guarantees the attention of the audience for the first 3 minutes. A speaker introduced as Dr Jones from Cleveland, who is going to talk about arthritis, has to fight for the first 5 minutes just to establish his credibility. Who does that harm? Not the speakers; they get paid either way. I am convinced, however, that the amount and quality of information transmitted in the latter circumstance is inferior. Time and time again, I have been confronted by a CME director who saunters up 2 minutes before the talk is to begin and mumbles, "Where are you from?" This same person has had my curriculum vitae for 2 weeks. What would be clearly recognized as incompetence in any other field is seen as normal behavior for physicians in charge of CME.

The best CME directors call the speaker beforehand to go over the content of the talk. That way, the speaker can modify the presentation to fit the needs of the audience. A speaker sponsored by a drug company to talk about treatment of hypertension can usually switch to another topic if the audience has been saturated with hypertension talks. The drug company representatives sponsoring the talks will not object. They cannot afford to alienate the CME directors.

Second, do the best you can with the CME room you have. Think about what contributes to a good presentation. If you are expecting an audience of 20 in a room that seats 100, find a way to get the audience down front to form a tighter, closer group. It is hard to establish contact with a physician at the back of the room. Speakers need that contact to know how the talk is going—do we need to slow down, speak up, or stop for questions? It is not difficult to get physicians to sit down front; some CME directors do it all the time. It just takes a little thought.

Distance between the speaker and audience is not the only variable under potential control of the CME director. I have started after-dinner talks wherein half of the audience was facing away from me. It is asking too much of a speaker to educate a group in which half of the audience is getting a stiff neck.

The previous two suggestions were for CME directors who do not think enough about what they are doing. This third suggestion is for CME directors who think too much. Do not fall in love with audiovisuals. Audiovisuals, if not a science (and certainly not an art), have evolved into a powerful technology, dominating continuing medical education. Many CME directors have become prisoners of the technology of CME, ignoring any negative effects on the outcome, which is education.

The absurdities of high-tech CME strain belief. I once gave a talk to eight physicians at the Veteran's Administration Hospital in Big Spring, Tex. They were scattered around an auditorium which seated well over 100. Planted directly in front of me was a television camera, and my picture was reproduced on eight television monitors distributed on the walls around the room. Guess where my audience was looking? I only had an occasional glimpse of them.

Many CME directors blanch when I ask for a blackboard and chalk. Some cannot provide them. Two bad things happen when a speaker uses slides: the lights go out and eye contact is lost. As a group, we physicians are poorly socialized creatures, not strong on rules for interpersonal behavior. We all seem to remember, however, that when someone is looking at us and talking to us, we should look back and listen. When the lights go off and the slides go on, all rules are off.

Another method of ruining CME is using a microphone. It is unnatural to listen to speakers and have their voices coming from behind you, complete with echoes. And it is also unnecessary. In the majority of CME

Continued on next page

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Continued from preceding page
rooms and auditoriums, microphones only add to the things that can go wrong.

Why are many professional CME directors so enamored of high-tech? In some cities there seems to be a competition among hospitals to provide the latest in CME technology. The controls on the speakers' podiums look like something out of a Star Trek episode. In the Sunbelt, any hospital worth its salt has $1,000,000 worth of electronics in the auditorium and a helicopter on the roof. Most need neither.

Fourth, allow the audience to drink coffee in the auditorium. If you cannot convince the hospital administration of the benefits of this approach, then at the very least do not put out an array of coffee and doughnuts just outside the door and forbid the audience to bring them inside. It is demoralizing to wade through a mass of physicians happily imbibing coffee and doughnuts, only to find a spotlessly clean, carpeted but nearly empty auditorium. Why ask your speakers to compete with coffee and doughnuts? Medical education is difficult enough as it is.

Fifth, play down the pretests, posttests, educational goals and all the other bureaucratic behaviors so loved by the state boards that certify CME. Individuals and organizations that require such paperwork should be condemned to read it. The goal of the CME director is to facilitate education. That may require the creative interpretation of state regulations rather than rigid adherence to them.

Finally, in my observations, the individual who wants to learn is rarely bored at CME talks. A certain percentage of physicians, and CME directors, seem almost threatened by the process of continuing medical education. It is as if, for them, any manifestation of interest in a presentation is an admission that they do not know everything. We all know physicians who know everything. Fortunately, the prevalence of these individuals decreases with age, either because they finally grow up, or (and this is a favorite fantasy of mine) because they experience premature and violent deaths at the hands of their colleagues.

Three decades ago, few practicing physicians participated in formal CME lectures and courses. Now the combination of state licensure requirements and the rapid evolution of medical knowledge has made CME a major and costly aspect of the health care system. Few would argue that the growth of CME is bad, but this rapid growth has aggravated inherent weaknesses in the system, forcing American physicians to address issues that had previously been irrelevant. These issues include everything from the proper role of the pharmaceutical industry in sponsoring CME to questions of whether CME actually beneficially influences medical care.

The individual physician is, at worst, a prisoner of this new industry, in that compulsory CME requirements have been for the most part imposed from above. The typical CME audience is not composed of volunteers; it has been drafted. Given this background, it is understandable why some CME directors and their audiences are less than enthusiastic in their approach to medical education. But CME directors have it within their power to improve their audiences' lot.❑

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Percutaneous balloon pulmonary valvuloplasty in children

Michael C. Zacharisen, MD, and David Z. Friedberg, MD, Milwaukee

This report describes the results and follow-up of 27 patients undergoing pulmonary balloon valvuloplasty at Children's Hospital of Wisconsin where this procedure has been performed since 1985. The valvuloplasty data at catheterization as well as follow-up echocardiograms when available were retrospectively reviewed. For 26 patients, the transvalvar gradient changed from a mean of 72 mm Hg + 5.2 (SEM) to 29 mm Hg + 4.4 (SEM) (p 0.00001) a mean gradient reduction of 58%. No major complications were reported and no patient went on to surgical valvotomy. Follow up echocardiograms were available for 26 patients. Average estimated transvalvar pressure gradients by continuous wave Doppler echocardiography were 28 mm Hg at one day (13 patients), 20 mm Hg at mean 1.5 months (18 patients), 23 mm Hg at mean 8.8 months (12 patients), and 19 mm Hg at mean 26 months (8 patients). Percutaneous balloon valvuloplasty gives good results in nearly all patients with pulmonary valve stenosis. *Wis Med J* 1991;90(1):15-18.

VALVAR PULMONARY STENOSIS with intact ventricular septum is a common congenital cardiac anomaly comprising as much as 10% of all congenital heart disease.[1] Surgical repair of isolated congenital pulmonary valve stenosis has been shown to be effective in relieving the physiologic abnormalities caused by a stenotic pulmonary valve.[2] Excellent overall survival has been documented both short and long term for patients undergoing surgical repair in the first and second decades of life.[3,4]

In recent years, the technique of transluminal balloon valvuloplasty (as used in the relief of stenotic coronary, renal and peripheral arteries) has been applied to treatment of stenotic cardiac valves–namely pulmonary, aortic, and mitral. Semb et al[5] in 1974 attempted percutaneous balloon valvuloplasty of a stenotic pulmonary valve in a newborn by manipulating a carbon dioxide filled balloon from the pulmonary artery to the right ventricle. In 1982, Kan et al[6] and Lock et al in 1983,[7] refined the technique. Radke et al[8] further improved the technique with oversized balloons. Lima and associates[9] have documented that measurement of maximal doppler jet velocities using echocardiography is useful as a reliable noninvasive method for evaluating the pressure gradient across a stenotic pulmonary valve.

This report describes the results of percutaneous transluminal balloon valvuloplasty for pulmonary valve stenosis in 27 patients at Children's Hospital of Wisconsin from 1985 to 1990.

Materials and methods

The medical records of all patients with pulmonary valve stenosis who underwent balloon valvuloplasty at Children's Hospital of Wisconsin from October 1985 to February 1990 were reviewed. Twenty-seven patients were identified: 12 males and 15 females. Ages of the patients ranged from 5 days to 14 years, with a mean of 3.9 years. Five patients had undergone cardiac catheterization prior to the valvuloplasty while the remaining 22 had both a diagnostic catheterization and a valvuloplasty during the same procedure. A single patient had a surgical pulmonary valvotomy 8 years previously. Echocardiograms, electrocardiograms and chest x-rays, when available, were reviewed for all patients. The pre-valvuloplasty right ventricular and pulmonary artery pressures and the post-valvuloplasty right ventricular and pulmonary artery pressures were recorded for each subject. In four patients where the main pulmonary artery could not be entered, an estimated pulmonary artery pressure of 25 mm Hg was used. In one patient, post-valvuloplasty right ventricular pressure

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and main pulmonary artery pressure were not recorded. Long term follow-up was assessed by reviewing echocardiographic data where the average peak systolic pressure gradient was estimated by the maximal doppler velocity using the modified Bernoulli equation.[10] For statistical analysis, comparisons were made using the student's paired t-test and data are presented as the mean added to the SEM.

Technique of valvuloplasty

After administration of standard premedication with a triple cocktail of meperidine (50 mg/cc), promethazine (25 mg/cc), and promazine (25 mg/cc, dose 0.1-0.3 cc/10 lb. of body weight) or morphine sulfate (0.1 mg/kg) subcutaneously and pentobarbital suppository (1.5 - 3 mg/kg) a right-heart or combined cardiac catheterization was performed from the femoral vein using standard procedure. In those patients with a patent foramen ovale, left-heart catheterization data was obtained without arterial puncture.

After evaluation of the motion and anatomy of the pulmonary valve using angiographic studies and measurement of the transvalvar systolic gradient using a pressure catheter, a determination was made if criteria for valvuloplasty were met. If they were, a guide wire was passed through the catheter into the distal pulmonary artery. The original cardiac catheter was removed and a balloon catheter inserted over the wire.

Appropriate sized balloon catheters from 6 French to 10 French were selected. These catheters had balloons which when inflated were 10 to 20 mm wide and 2 to 4 cm long. The size of the catheter selected depended on the diameter of the pulmonary valve annulus as measured on cine-angiography or on the patient's size. The deflated balloon was advanced along the guide wire until it straddled the stenotic pulmonary valve. While viewing under fluoroscopy, the balloon was rapidly inflated with dilute contrast media multiple times by hand while the operator observed the disappearance of the "waist" (Fig 1 and Fig 2). The balloon catheter was then withdrawn after the absence of the "waist" was documented. Pressure measurements and angiography were again performed to measure the success of the procedure. The catheters were then removed and pressure applied to the insertion site to control bleeding.

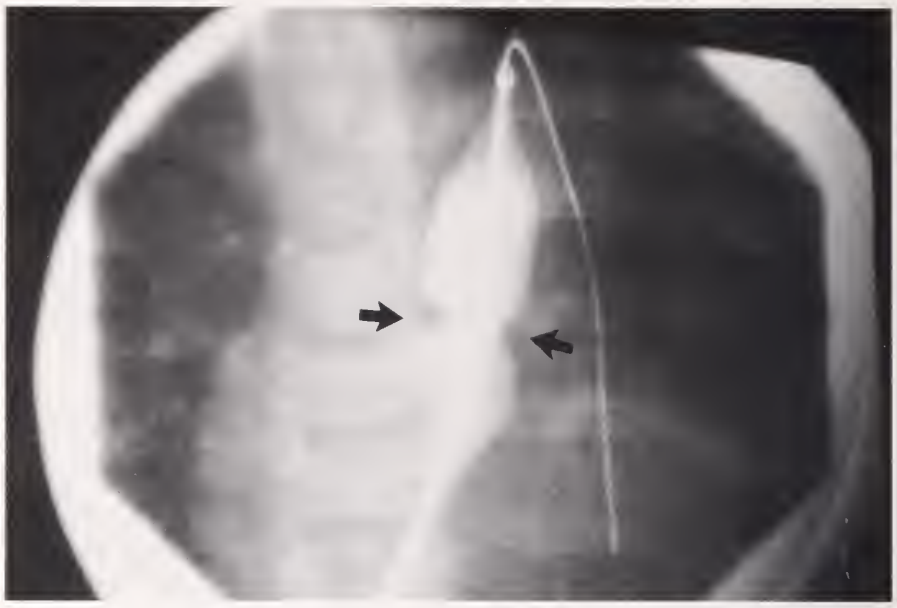

Fig 1.–Initial inflation demonstrates a "waist" (arrows) associated with the region of stenosis.

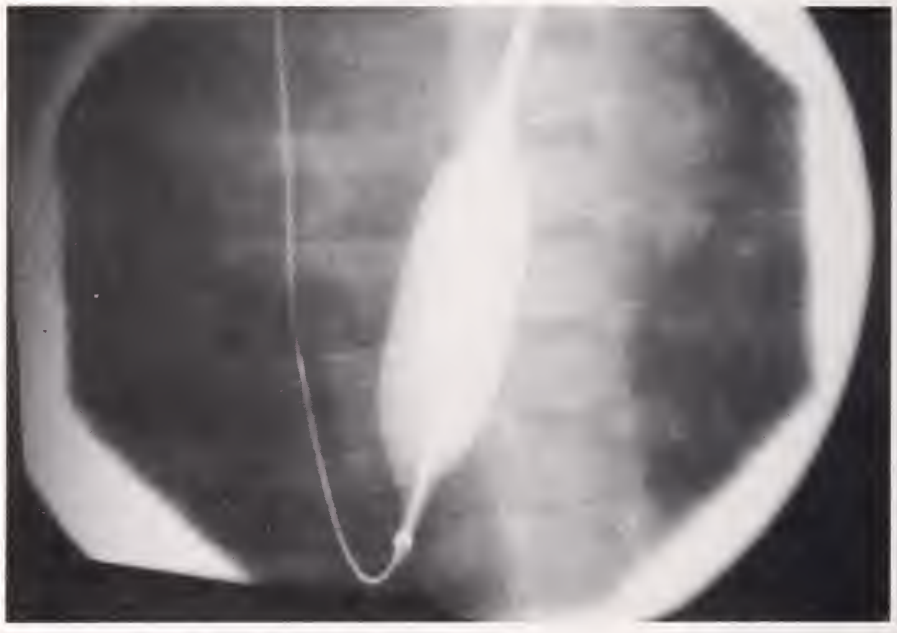

Fig 2.–After relief of the stenosis, full inflation of the balloon with disappearance of the "waist."

Results

The ages of the subjects ranged from 5 days to 14 years; six patients were younger than 1 year old. None of the patients underwent a repeat val-

vuloplasty and none had surgical repairs following the procedure.

Right ventricular pressures prior to the procedure ranged from 55 mg Hg to 145 mm Hg (mean 92 mm Hg+5.2). In 11 patients (41%), the pressure was near or above systemic levels. Immediately following valvuloplasty, right ventricular pressure decreased to a range of 28 mm Hg (mean 53 mm Hg+4.2) (p 0.00001) (Fig 3).

The mean initial transvalvar gradient was 72 mm Hg+5.2 (range 35-123 mm Hg) while the post-valuloplasty gradient was reduced to an average of 29 mm Hg+4.4 (range 2-105 mM Hg) (p 0.00001). The mean gradient reduction was 58% (Fig 3). All pressure measurements were made before cineangiograms were performed so as to reduce dye-induced pressure changes. At valvuloplasty, seven patients were noted to have an element of infundibular obstruction.

Each patient, however, responded to balloon dilatation with transvalvar gradient reduction from mean 101 mm Hg + 7.8 (range 70-123 mm Hg) to mean 46 mm Hg + 13.4 (range 7 to 105 mm Hg), P 0.01. If these patients with secondary infundibular stenosis are excluded from analysis, the mean transvalvar pressure gradient post-dilatation would decrease to 21 mm Hg.

In six patients, a larger balloon catheter was inserted after initial inflations did not succeed in reducing the gradient. In these patients, a decrease in mean transvalvar gradient was documented to be 56% (range 23% to 88%).

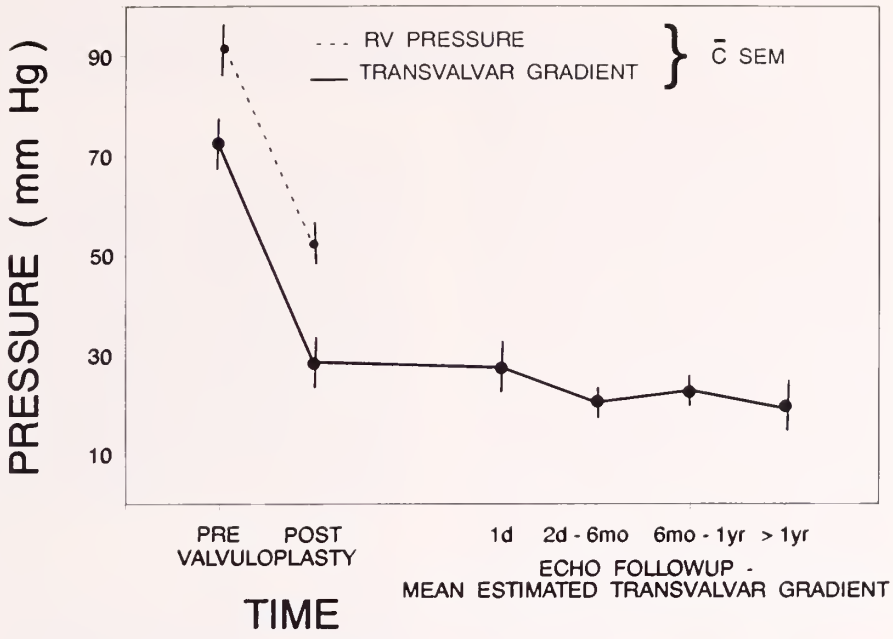

Fig 3.–Mean right ventricular pressure and pulmonary transvalvar pressure gradients before and after balloon valvuloplasty.

Complications

No significant complications were reported during any of the valvuloplasty procedures. Events which occurred included mild transient bradycardia (five patients) and balloon rupture (nine patients). Blood loss sufficient to require transfusion occurred in four patients. Brief cardiac arrhythmias occurred in seven patients. These included transient nodal rhythm with third-degree heartblock, supraventricular arrhythmia with and without block, isolated premature ventricular contractions and transient complete heart block. None of these persisted after the valvuloplasty procedure was completed. No patient was hospitalized beyond 2 days due to the valvuloplasty procedure.

Long term follow-up

Twenty-five patients had follow-up continuous wave doppler echocardiograms 1 day to 51 months (mean 11.9 months) post-procedure. Twenty-two patients had echocardiograms beyond 1 day. The remaining five patients were lost to follow-up.

All echos were performed without sedation. Follow-up echocardiograms were grouped into the following time spans: group 1–1 day (13 patients); group 2–2 days to 6 months (mean 1.5 months) (18 patients); group 3–6 months to 1 year (mean 8.8 months) (12 patients); and group 4–greater than 1 year (mean 26 months) (8 patients). Average transvalvar pressure gradients were 28 mm Hg + 4.6 for group 1; 20 mm Hg + 2.4 for group 2; 23 mm Hg + 2.9 for group 3; and 19 mm Hg + 4.4 for group 4 (Fig 3). The average transvalvar pressure gradient in six patients with infundibular narrowing who had an echocardiogram was 20 mm Hg at average of 6 months (range 1 to 15 months) post-procedure, a spontaneous average decrease of 26 mm Hg.

Discussion

Transcatheter therapy is being used frequently to treat or palliate infants and children with cardiovascular disorders. Although some applications are still experimental, percutaneous balloon valvuloplasty for uncomplicated moderate to severe congenital pulmonary valve stenosis is generally accepted as the procedure of choice.

Our results show that most of those patients who underwent valvuloplasty had evidence of improvement immediately after valvuloplasty and that this persisted in the intermediate term. Since 1982, several hundred balloon valvuloplasty procedures for pulmonary stenosis have been performed by others and have shown reductions in average transvalvar

gradient ranging from 57% to 79%.[11] Our result of 58% is comparable to these previous studies. As with earlier studies, no instances of major morbidity or mortality were observed. In those seven patients without infundibular stenosis whose response at catheterization was less than expected (greater than or equal to 25 mm Hg gradient post-procedure), we feel they may have benefited from oversized balloons or the double balloon technique described by Mullins and Associates.[12] At follow-up, two patients developed restenosis. One patient was later believed to have Noonan's Syndrome which historically is associated with dysplastic pulmonary valves. Valvuloplasty is relatively ineffective in patients with a dysplastic pulmonary valve, but in some cases may be palliative.[13] The other patient had mild stenosis initially, poor results at valvuloplasty and similar pressure gradients at follow-up. The reason is unclear.

Nishimura et al have reported instances where intermediate term follow-up at 1 to 3 years revealed no evidence of restenosis.[14] The gradient across the pulmonic valve decreased at follow-up compared to immediately after valvuloplasty in those patients noted to have an element of infundibular obstruction. Regression of infundibular hypertrophy has been shown to occur spontaneously after the stenosis has been relieved.[15]

Although the risk of a surgical procedure is minimal, valvuloplasty offers the advantages of a shorter hospital stay, a less expensive procedure, minimal scarring, and avoidance of the risks of cardiopulmonary bypass. For these reasons, transcatheter pulmonary valvuloplasty is the procedure of choice for treatment of patients with valvar pulmonary stenosis at Children's Hospital of Wisconsin.

Addendum

Since completion of this report, five additional patients ages 15 months to 15.6 years (mean 5.3 years) have undergone percutaneous balloon valvuloplasty at Children's Hospital of Wisconsin. The mean transvalvar pressure gradient before valvuloplasty was 49 mm Hg (range 30 to 91) and after valvuloplasty, 20 mm Hg (range 4 to 55). No complications occurred.

Acknowledgement

The authors wish to thank Dr William J. Gallen and Dr John P. Thomas for allowing them to include their patients in this study.

References

1. Dalen JE, Alpert JS, eds. *Valvular Heart Disease*. 2nd ed. Little Brown and Company; 1987;403.
2. Blount SG, McCord MC, Mueller H, et al. Isolated valvular pulmonic stenosis. Clinical and psysiologic response to open valvuloplasty. *Circulation*. 1954;10:161-172.
3. Tandon R, Nadas AS, Gross RE. Results of open-heart surgery in patients with pulmonic stenosis and intact ventricular septum, a report of 108 cases. *Circulation*. 1965;31:190-201.
4. Kopecky SL, Gersh BJ, McGoon MD, et al. Long-term outcome of patients undergoing surgical repair of isolated pulmonary valve stenosis, follow-up at 20-30 years. *Circulation*. 1988; 78:1150-1156.
5. Semb BKH, Tjonneland S, Stake G, et al. Balloon valvulotomy of congenital pulmonary valve stenosis with tricuspid valve insufficiency. *Cardiovascular Radiology*. 1979;2:239-241.
6. Kan JS, White RI, Mitchell SE, et al. Percutaneous balloon valvuloplasty: A new method for treating congenital pulmonary valve stenosis. *N Eng J Med*. 1982;307:540-542.
7. Lock JE, Castaneda-Zuniga WR, Fuhrman BP, et al. Balloon dilatation angioplasty of hypoplastic and stenotic pulmonary arteries. *Circulation*. 1983;67:962-967.
8. Radtke W, Keane JF, Fellows KE, et al. Percutaneous balloon valvotomy of congenital pulmonary stenosis using oversized balloons. *Journal of the American College of Cardiology*. 1986;8:909-915.
9. Lima CO, Sahn DJ, Valdes-Cruz LM, et al. Noninvasive prediction of transvalvular pressure gradient in patients with pulmonary stenosis by quantitative two-dimensional echocardiographic doppler studies. *Circulation*. 1983;67:866-871.
10. Hatle L, Angelsen B. *Doppler Ultrasound in Cardiology*. Lea and Febiger; 1982;72.
11. Tingelstad JB. Percutaneous balloon valvuloplasty for congenital pulmonary stenosis. *Pediatrics in Review*. 1988;10:179-182.
12. Mullins CE, Nihill MR, Vick GW, et al. Double balloon technique for dilatation of valvular or vessel stenosis in congenital and acquired heart disease. *Journal of the American College of Cardiology*.1987; 10:107-114.
13. Marantz PM, Huhta JC, Mullins CE, et al. Results of balloon valvuloplasty in typical and dysplastic pulmonary valve stenosis: Doppler echocardiographic follow-up. *Journal of the American College of Cardiology*. 1988;12:476-479.
14. Nishimura RA, Holmes DR, Reeder GS. Percutaneous balloon valvuloplasty. *Mayo Cli Pro*. 1990; 65:198-220.
15. Rao PS, Fawzy ME, Solymar L, et al. Long-term results of balloon pulmonary valvuloplasty of valvar pulmonic stenosis. *American Heart Journal*. 1988;115:1291-1296.❑

The smoking cessation process

Mary E. Wierenga, RN, PhD, Milwaukee

The purpose of this study was to identify and describe the smoking cessation process as perceived by smokers and ex-smokers. In-depth, open-ended interviews were conducted with 25 ex-smokers who had quit smoking for at least 1 year, but not more than 7 years, and 22 smokers who had quit smoking for at least 2 weeks and returned to smoking. A systematic analysis of content was used to generate categories of responses regarding the smoking cessation process. The results of this study support and enhance what is known about behavioral change. Although further testing for verification is needed, the smoking cessation process as described by the study participants is: thinking about quitting, making a case, quitting, making adjustments, meeting the challenge, resumption, or maintenance. *Wis Med J* 1991;90(1):19-21.

Behavioral change, such as smoking cessation, has been described as a cyclic process consisting of five stages: precontemplation, contemplation, action, relapse, and maintenance.[1,2] Although not much is known about the precontemplation stage, contemplation is a time of gathering information and evaluating the behavior to be changed. Because of the complex nature of the change process and the multiple factors that affect change, action may be initiated before a thorough evaluation of the advantages and disadvantages are considered and a plan for cessation is developed. Without this planning, action strategies may be ineffective resulting in partial or complete relapse. Several factors have been shown to affect relapse such as crisis situations,[3] social desirability,[4] negative emotions, social pressure, and interpersonal conflict.[5,6] The rate of relapse for a smoking cessation attempt ranges from 61%[7] to 83%.[8] Relapse usually occurs several times before smoking cessation can be maintained.[9] When relapse does occur the smoker frequently returns to the contemplation stage to reevaluate the problem behavior.[10]

Although considerable investigation has been conducted in the area, no studies were found in which behavior change was described from the perspective of persons who have experienced the smoking cessation process. The purpose of this research was to identify and describe the smoking cessation process as perceived by persons who have successfully quit smoking and those who have attempted to quit but returned to smoking.

Method

The study sample consisted of two groups of volunteers (N=47) who responded to a notice in the newspaper; 25 ex-smokers who had quit smoking for at least 1 year but not more than 7 years, and 22 smokers who had quit smoking for at least 2 weeks but returned to smoking. The demographic characteristics of the smokers and ex-smokers were similar. The sample consisted of 17 males and 30 females who ranged in age from 27 to 77 years.

The difference in cigarettes smoked per day by ex-smokers (M = 2.12 packs) and smokers (M = 1.81 packs) was not significantly different but the difference between men (M = 2.29 packs per day) and women (M = 1.80 packs) was significant, $t(45) = 2.73$, $p = 0.01$. Ex-smokers had tried to quit significantly more times (M = 2.96) than smokers (M = 2.14), $t(45) = -2.32$, $p = 0.025$. There was no significant difference in smoking cessation between persons who attended (n = 18) or did not attend (n = 29) smoking cessation programs. Fifteen of the ex-smokers had quit without attending a formal program.

The study participants were asked to tell their "smoking story" in open-ended, in-depth audiotaped interviews. These one-time only interviews lasted from a half-hour to 1.5 hours. After the interview, a short demographic and smoking history questionnaire was completed. The interviews were transcribed verbatim and the data were analyzed using a systematic analysis of the content as described by Miles and Huberman.[11]

To promote rigor in the analysis procedure, a process of consensus was employed among the team of the investigator and two doctoral student assistants. The team of researchers reviewed, discussed, and eventually, reached consensus on what constituted the data, generation of preliminary categories, assignment of data to these categories, and the definitions of the categories.

The first step in the analysis was designed to develop coding categories. The data from transcripts of five ex-smokers were reduced to individual thoughts, events, or happenings to allow exploration of the data with minimal preconception. Initial categories were formed by clustering similar pieces of information. Several transcripts were coded to verify and modify the preliminary coding categories and their definitions. The same process was followed when it was de-

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termined that the coding categories needed to be augmented to include additional categories for smokers. Once the categories were identified and defined to the satisfaction of the researchers, all the transcripts were coded using this coding scheme. The contents of each coding category were compared within and across categories for similarities and dissimilarities. This process led to merging and collapsing of similar categories. First the data were reduced and each entity was analyzed. In the rebuilding stage, the data were reconstructed using theoretical knowledge, the research question, and the natural groupings of the data to form theoretical constructs.

Results

Seven major categories or theoretical constructs were identified in the final analysis. When reviewed in totality, the categories depicted a smoking cessation process of change. It was clear, however, that individuals in this study did not progress through the process in a linear fashion. For the purpose of clarity, the categories are presented in a sequential manner although the relationship of these categories within the process is not known.

In the first category, called "thinking about quitting," participants expressed beginning to feel out of place when smoking because they now are in the minority. They described external pressure such as being asked to smoke outdoors regardless of weather conditions as stimulating smoking cessation thoughts. Smokers also reported becoming aware of their appearance with a cigarette and annoyance with their cough. Many participants reported quitting because smoking was becoming socially unacceptable. One person stated, "...maybe it would be easier to quit than to put up with this hassle or to be treated like an outcast, like a leper."

The second category is called, "making the case." Participants described shopping for cures, listing reasons for quitting, cutting down, and changing their smoking patterns to prepare for quitting. Most smokers, however, remained in a contemplation stage planning to quit "someday" and making excuses for their continued smoking. Smokers reported they would know when "the time was right" to quit. One person described, "It will be just suddenly, you know just one day I wake up and if I get by that first one I stand a good chance." Several smokers reported reading articles about smoking cessation so they would be ready for the magical quit day. Persons who were successful had spent time thinking about the negative aspects of smoking and preparing themselves for quitting by "self brainwashing," "educating myself," and being disgusted with the habit. Several persons described taking some time to convince themselves and then "making up my mind" to quit.

Differences exist between smokers and ex-smokers in this category. Consistent with the literature,[12,13] ex-smokers stressed mental preparation as opposed to more behavioral activities (eg postponing the first cigarette in the morning, cigarette rationing) reported by smokers. Ex-smokers reported evaluating the problem behavior and analyzing the assets and liabilities of smoking. Reading articles about the "evils of smoking" reported by both groups is consistent with gathering information seen during the contemplation stage.[1,2]

The third category, "quitting," represents enactment of smoking cessation. Some people reported a "turning point" that made them want to quit, some reported getting more disgusted with themselves and finally making a decision to quit while others reported that they just quit without thinking about it.

Actions associated with quitting ranged from throwing away cigarettes and lighters to keeping cigarettes in the refrigerator "just in case." Quitting with someone, the "buddy system," had mixed results.

Category four is entitled, "making adjustments for the change." The response to quitting smoking ranged from no symptoms to withdrawal symptoms so severe that one person went to the emergency room and several went to their physicians. Quitting smoking affected bowel habits, sleep patterns, sinuses, daily routines, and socializing. Substitutes for smoking ranged from gum and food to a fake cigarette. Although some positive benefits of smoking cessation (food tasted better) were reported, most people did not report benefits spontaneously. When asked, they could identify some effect (decreased shortness of breath) but these usually were not present until several months after quitting.

Although most participants reported using a variety of strategies, there were some differences between smokers and ex-smokers in this category. Ex-smokers reported trying to keep busy so they would not think about smoking or to think negative thoughts. Smokers reported their behavioral activities but did not report thought processes to keep from smoking. Also, the benefits of smoking cessation were identified by ex-smokers but not by smokers.

Category five is called, "meeting the challenge." Stress and finding or having access to a single cigarette were considered a test to see if smoking cessation could be maintained. Participants related specific situations in which they thought their smoking cessation had been tested and they had passed the test.

In the sixth category, "resumption of smoking," the relapse process was described. Almost all participants described a relapse experience. It usually started as a partial relapse, sneaking one or two cigarettes, then gradually "breaking down the barriers" and smoking in front of family and friends again. Access to cigarettes initiated smoking resumption and appeared to be the easiest at work and social situations. Many smokers reported returning to smoking fol-

lowing only one experience with a cigarette. Some people reported being smoke-free for 8 to 15 years before returning to smoking.

Consistent with the literature,[7,9,10] stress or crisis situations and interpersonal conflicts were frequently described as reasons for resumption of smoking. Respondents also emphasized the distress caused by weight gain, not being prepared for the number and magnitude of withdrawal symptoms, and health problems arising after they quit (eg, increased amounts of phlegm) that contributed to smoking relapse. One surprising reason for resuming smoking was childbirth. Women reported quitting smoking to protect their unborn child but resumed smoking immediately after delivery.

The last category, "maintenance," represents the internalization of the behavioral change. One person stated, "I found cigarettes occupied my thinking less and less." Another said, "I can't even tell you what brand I smoked." These people had thoroughly integrated the behavioral change into their lifestyle. Other exsmokers did not accept the change. As one person who equated smoking with addiction stated, "I'm happy [that I am not smoking] but I still want it at the same time. I want it, not cognitively, my body wants it."

Discussion

Smokers and ex-smokers who volunteered to be interviewed regarding their smoking cessation experience describe the process as: thinking about quitting, making a case, quitting, making adjustments, meeting the challenge, resumption, or maintenance. The purpose of this study was to describe behavioral change from the perspective of persons who had attempted to quit smoking and were successful and those who attempted to quit smoking and were not successful. Because this study depended on the participant's ability to recall accurately events associated with their smoking cessation, the findings need to be verified before they can be generalized. It is with this limitation in mind that this discussion is undertaken.

The smokers'and ex-smokers'perspectives support and enhance what is known about the smoking cessation process. The first two categories appear to be analogous to the contemplation stage described by Prochaska and Di Clemente.[1,2] Thinking about quitting, an early stage of the smoking cessation process, is initiated by physical or mental discomfort (eg, coughing, feeling out of place). As the discomfort increases, the individual thinks about quitting more seriously and attempts to convince him or herself to take action by making a case for quitting. The results of this study provide information regarding how people prepare for a behavioral change and support the findings of previous research [12,13] that mental preparation appears to be more successful than behavioral activities. The stimulus for action may or may not be recognized.

The respondents did not report (other than setting a stop date) specific plans on how they would make the change or anticipation of how the change would affect them. Thus, they were not prepared for the effect smoking cessation had on other aspects of their lives (eg, weight control). Challenges such as social pressure to smoke and use of smoking as a coping mechanism for stress had to be successfully overcome or the individual was at risk for relapse.

Consistent with behavioral change research, ex-smokers in this study reported more quit attempts than smokers. Because the assets and liabilities of the change are not thought out with a plan of action, strategies become ineffective and the smoker recycles to the contemplation stage to reevaluate the behavior. A better understanding of the process can lead to more careful planning and increase the chance for success. Thus, persons who have attempted behavioral change and relapsed may be better prepared to successfully change their behavior because of this experience.

Based on this description of the change process from smokers and ex-smokers, health care professionals can identify people contemplating change and plan interventions to assist clients move through the change process more effectively.

References

1. Prochaska JO, Di Clemente CC. Stages and processes of self-change of smoking: Toward an integrative model of change. *J Consult Clin Psychol.* 1983; 51:390-395.
2. Prochaska JO, Di Clemente CC. Toward a comprehensive model of change. In Miller W, Heather N, eds. *Treating Addictive Behaviors.* New York: Plenum, 1986.
3. Cummings KM, Jaen CR, Giovino G. Circumstances surrounding relapse in a group of recent exsmokers. *Prev Med.* 1985;14:195-202.
4. Fishbein M, Ajzen I. Belief, attitude, intention and behavior: An introduction to theory and research. Reading, Mass: Addison-Wesley, 1975.
5. Marlatt GA, Relapse prevention. Theoretical rationale and overview of the model. In Marlatt GA, Gordon JR, eds. *Relapse Prevention.* New York: Guildfor Press, 1986:3-70.
6. Schiffman S. Relapse following smoking cessation: A situation analysis. *J Consult Clin Psychol.* 1982;50:71-86.
7. Wewers ME, Lenz ER. Relapse among exsmokers: An example of theory derivation. *Advance in Nsg Sci.* 1987;9:44-53.
8. Scott RR, Prue DM, Denier CA, et al. Worksite smoking intervention with nursing professionals: Long-term outcome and relapse assessment. *J Consult Clin Psychol.* 1986;54:809-813.
9. Brownell K, Marlatt GA, Lichenstein E, et al. Understanding and preventing relapse. *Amer Psychol.* 1986;41:765-782.
10. O'Connell D, Velicer WF. A decisional balance measure and the stages of change model for weight loss. *Int J Addict.* 1988;23:729-750.
11. Miles MB, Huberman AM. *Qualitative data anaylsis: A source book of new methods.* Beverly Hills: Sage, 1984.
12. Prochaska JO, Velicer WF, Di Clemente CC, et al. Measuring processes of change: Application to the cessation of smoking. *J Consult Clin Psychol.* 1988;56:520-528.
13. Glasgow RE, Klesges RC, Mizes JS, et al. Quitting smoking: Strategies used and variables associated with success in a stop-smoking contest. *J Consult Clin Psychol* 1985;905-912.❑

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Mortality and morbidity in Wisconsin hospitals

Vernon B. Hunt, MD, Madison

Last month, the practice patterns of the medical staff of Wisconsin Hospitals became public. The state legislature mandated the Office of Health Care Information (OHCI) to publish a yearly report on hospital morbidity and mortality based upon administrative data collected from the uniform billing form. Little clinical data is reported on this fiscal form. The report should not be used to compare hospital-specific rates, rather, it should be used by each hospital to evaluate its performance. Wisconsin physicians need to be able to interpret and discuss their hospital's data.

The in-hospital mortality rates for Wisconsin hospitals are available for public review. In 1987, the state legislature[1] passed legislation which requires the OHCI Department of Health and Social Services to publish annual reports setting forth mortality and morbidity rates for every hospital. The first report, based upon data submitted for patients hospitalized during 1989, was published during December 1990. State law requires each hospital to send specific elements for each patient from the uniform billing form (UB-82) to OHCI on a quarterly basis. The UB-82 was designed for fiscal and administrative purposes not to evaluate the quality of medical care. Health services research[2,3] has shown, however, that certain data elements on the UB-82 may be useful to individual hospitals to judge the quality of their own practice. There is not adequate data on the UB-82 to make valid comparisons of the quality of medical practice among a group of hospitals. To make valid judgements of the quality of care, medical records of individual patients need to be evaluated.[4]

An Overview of Hospital Mortality and Morbidity in Wisconsin: General Medical-Surgical Hospitals, 1989[5] is not an attempt to rank order the quality of hospital care in Wisconsin hospitals. It is a source of information for the general public. Medical staffs and hospital administrators can use statewide rates as benchmarks when evaluating their hospital's clinical performance. OHCI realizes that attempts will be made to use hospital specific data to make quality of care comparisons among hospitals. The law requires OHCI to notify each hospital of its specific data and to give the hospital 30 days to comment. In its reports,[5] OHCI will publish the hospital-specific data and the hospital's response.

The modern era of hospital mortality reports dates to 1986 when the Health Care Financing Administration (HCFA) released data on the mortality of Medicare patients.[6] Florence Nightingale,[7] however, suggested in 1858 that the quality of medical practice in a hospital is reflected by its mortality rate. Codman,[8] in the early 1900s, thought that hospitals should be rated on their morbidity and mortality rates. The OHCI report should encourage each hospital to evaluate its practice and make needed alterations.

Morbidity and mortality rates may differ among hospitals for several reasons. Florence Nightingale proposed two:[6] hospitals with higher rates either had sicker patients or had a poorer quality professional staff. Many factors other than the quality of medical practice affects a hospital's mortality rate.[9] A hospital might just be lucky; whenever you rank individuals one has to be the best and someone else the worst. A hospital's death rate also differs if one uses in-hospital mortality rates or if one uses rates based on death within 30 days of admission to a hospital. If a hospital transfers all of its terminally ill patients to a nursing home or transfers them to a swing bed, it would have a lower inhospital mortality rate than if all terminal patients were permitted to die as hospital patients. The policy of transfer of terminally ill patients to a nursing home, however, would have very little effect on a 30-day death rate. HCFA[10] publishes rates based on deaths within 30 days of a hospital admission; OHCI[5] mortality rates are in-hospital death rates. A medical staff's practice patterns (eg, do not resuscitate policies, decisions to transfer terminally ill patients to or from nursing homes, the availability of a hospice, and the triage arrangements for severe trauma) affect a hospital's mortality rate. The severity of illness treated in a hospital also has an effect on its mortality rate,[11] but no universally accepted method of comparing case severity among hospitals exists.[12]

The OHCI's hospital mortality rate is an in-hospital mortality rate. The numerator is the in-hospital deaths for all in-patients. It does not include death on arrival to a hospital's emergency room or the death of any patient transferred to a swing bed. The denominator is all discharges from the hospital. In addition to the overall mortality rate, the mortality rate is reported for up to 12 common clinical conditions. OHCI regrouped the discharge diagnoses on the UB-82 by the standard diagnosis related groups (DRG). Then several DRGs were combined into the following report categories: acute myocardial infarction and other acute cardiac disease,

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pulmonary disease, cerebral vascular disease, congestive heart failure, septicemia, gastrointestinal disease, coronary artery bypass surgery, major joint surgery, major peripheral vascular surgery, gastrointestinal surgery, prostatectomies, and gynecological operations. The number of discharges, the number of deaths, the number of deaths occurring on the first hospital day, an unadjusted rate per 100 discharges, and an adjusted rate per 100 discharges were reported. The adjusted rate compares the observed rate to a predicted rate based on a logistic regression model which controlled for age, gender, source of patient, and relative contribution of groups of DRGs to a report category. The adjustment performed by OHCI does not control for severity of illness other than by the DRG category and the source of admission. The adjusted rate is standardized to the statewide unadjusted rate. The analytical comparison is between a hospital's adjusted rate and the statewide rate. If a hospital's unadjusted rate is lower than the statewide rate, it reflects that the hospital's clinical population may be younger, may be more female, has fewer admissions from the emergency department, or has fewer transfers from nursing homes.

All of these factors have been shown to be negatively correlated with in-hospital death rates.[3,4,8] If a hospital's unadjusted rate is higher than the statewide rate, it may reflect that the hospital cares for an older more male population with more admissions from the emergency department or transfers from nursing homes. The adjustment in the rates by the logistic regression model removes the variation caused by the variables which it contains. If a hospital's adjusted rate is lower than the statewide rate, it reflects that the medical care in this hospital may be better or that the patients cared for in the hospital were less severely ill than the statewide average. If a hospitals adjusted rate is higher than the statewide rate, it reflects that the patients may be sicker or that the quality of medical practice may be poorer. Interpretation of the rates depends on the type of hospital; the inference drawn from a rate may be different for a small community hospital and a large referral center.

The report contains three other rates: transfer to another hospital; transfer to a nursing home; and length of stay greater than the statewide ninetieth percentile. Only unadjusted rates are reported since limited health service research has been done on these in-hospital rates. Transfers to another acute care hospital reflect both the transfers from a local hospi-

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tal to a referral center for more advanced care, and transfer from a referral center to a local hospital for terminal care. Transfers to nursing homes reflect the need for prolonged nursing care. Long lengths of stay[13] could reflect in-hospital complications, more advanced stages of the disease upon admission, or the presence of comorbid conditions. These three rates may reflect more on the severity of the disease cared for in a hospital rather than be a measure of the quality of care practiced in a hospital.

An Overview of Hospital Mortality and Morbidity in Wisconsin: General Medical-Surgical Hospitals, 1989[5] is the initial report required by state statute. Experience will improve future reports. Limitations of the report are based on lack of standardized reporting patterns for the UB-82, lack of detailed clinical data on the UB-82, and lack of research on the relationship between the data on the UB-82 and the quality of medical care practiced in a particular hospital. The hospital specific data can be properly interpreted only by the staff of the specific hospital. The report should permit the quality improvement programs of individual hospitals to better evaluate their practice patterns. If this occurs, the legislature's intent behind making in-hospital practice patterns public will be beneficial to Wisconsin residents.

Acknowledgment

The author thanks the other members of the Mortality and Morbidity Technical Advisory Committee, a multidiscipline group of Wisconsin health professionals and the staff of the Office of Health Care Information.

References

1. Chapter 153 Wisconsin Statutes as amended by WIsconsin Act 18, 1989.
2. Dubois RW, Brook RH, Rogers WH. Adjusted hospital death rate: A potential screen for quality medical care. *Am J Public Health.* 1987;72:1162-1166.
3. Fink A, Yano EM, Brook RH. The condition of the literature on difference in hospital mortality. *Medical Care.* 1989;27:315-336.
4. Dubois RW, Rogers WH, Moxley JH, et al. Hospital inpatient mortality: Is it a predictor of quality. *N Eng J Med.* 1987;317:1674-1680.
5. Office of Health Care Information. *An overview of hospital mortality and morbidity in Wisconsin: General Medical Surgical Hospitals, 1989.* Madison WI: 1990. (At press)
6. Health Care Financing Administration. *Medicare Hospital Mortality Information 1986.* Washington, DC: Government Printing Office, 1987.
7. Smith, FB. *Florence Nightingale: Reputation and power.* London: Groom Helm LTD; 1982.
8. Codman, EA. *A Study in Hospital Efficiency as demonstrated by the case report of the first five years of a private hospital.* Boston: Thomas Todd Co. Printers; 1917.
9. Dubois, RW. Hospital mortality as an indicator of quality. In: Goldfield N and Nash DB, eds. *Providing quality care: The challenge to clinicians.* Philadelphia: American College of Physicians, 1989.
10. Health Care Financing Administration. *Medicare Hospital Morbidity Information, 1987.* Washington, DC: Government Printing Office, 1988.
11. Green J, Wintfeld N, Sharkey P, et al. The importance of severity of illness in assessing hospital mortality. *JAMA.* 1990;263:241-246.
12. Iezzoni, LI. Measuring the severity of illness and case mix. In: Goldfield N and Nash DB, eds. *Providing quality care: The challenge to clinicians.* Philadelphia: American College of Physicians, 1989.
13. Jencks SF, Williams DK, Kay TL. Assessing hospital-associated deaths from discharge data: The role of length and stay and co-morbidities. *JAMA.* 1988;260:2240-2247.❑

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Observations on Wisconsin's public health agenda

Forecasting is especially difficult when it involves the future!
–William E. Scheckler, MD
Public Health Agenda Implementation Conference

THE 1990 STATE REPORT, *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000*, was the result of a collaboration of public and private interests fostered by the Wisconsin Department of Health and Social Services. The objective of the agenda is to reduce preventable death, disease, and disability among Wisconsin residents by the year 2000. In many areas, the state public health agenda parallels the goals set for the US in Healthy People 2000, the US Public Health Service proposal.

The state agenda was the product of work begun in December 1988, when more than 150 representatives from health, government, business, labor, education and voluntary organizations began to assess to the public health needs of Wisconsin over the next ten years. SMS Secretary-General Manager Thomas L. Adams, CAE, served on the 14-member Public Health Plan Steering Committee. William E. Scheckler, MD, of Madison, represented the SMS as the various work groups constructed the specifics of the agenda over the course of 2 years.

A statewide implementation conference was held at Wausau on June 26 and 27, 1990. The conference followed several earlier regional implementation conferences. At the statewide conference invited participants discussed implementation strategies and pledged the commitment of their respective organizations to select goals of the agenda.

Although development of the agenda was facilitated by Department of Health and Social Services, no state funding was provided for the implementation of the plan. The Bureau of Community Health and Prevention within the DHSS is charged with facilitating the implementation of the agenda. Currently, the plan's goal of better health for Wisconsin citizens by the year 2000 anticipates that local public and private health entities and associations will accept and work to meet the plan's objectives.

The public health agenda focuses on four general areas:

- the diagnosis and prevention of chronic and communicable disease;
- injury prevention;
- environmental health; and
- maternal, child and adolescent health.

Improving health in Wisconsin

The public health agenda sets out specific goals and implementation steps to reduce preventable illness, disability and death and to improve the surveillance of disease in the state. The bedrock of the public health agenda is prevention. In his concluding charge to the participants at the statewide implementation conference, Dr Scheckler stated: "So I'll make a prediction: In Wisconsin, the '90s will be the decade of prevention, and none too soon. We'll recognize that we can't afford to spend excessive health care dollars on the end of life, to spend 50% of hospitals charges for the last 30 days of life. The '90s will see *Healthier People in Wisconsin* transformed into a shared agenda by every group represented here."

The groups he referred to included local and state public health agencies, bureaus, and offices; medical, health, and helping professionals, such as nurses, doctors, dentists, social workers, counselors, pharmacists; business, labor, professional societies, volunteer groups. Dr Scheckler noted that the wide array of interests were drawn together "Because we believe in what this document is trying to articulate, and we believe together we have a real chance to make a difference."

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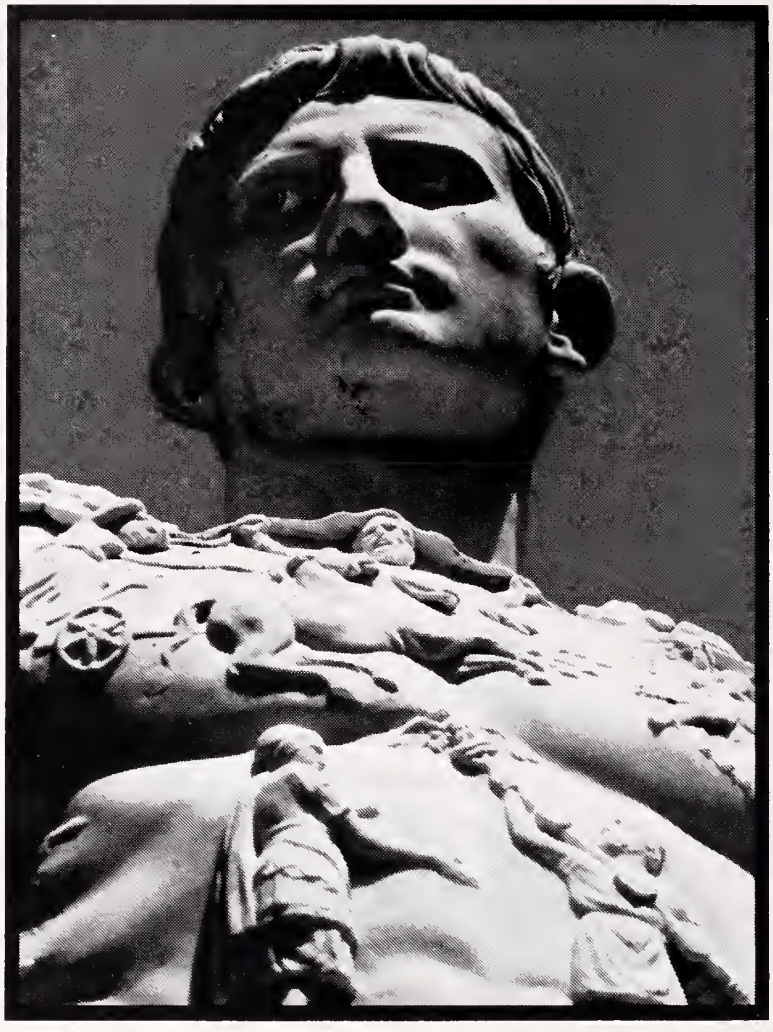

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Communicable diseases

Despite advances in sanitation, immunization and the development of antibiotic drugs, significant morbidity and mortality continue as a result of inadequately controlled and newly emerging infectious agents and disease. It is estimated that annually in Wisconsin, 14.8 million individual infections are responsible for 3,900 deaths, 840,600 hospital days and $343.8 million in direct costs. The agenda sets specific goals in the reduction of sexually transmitted diseases, specifically chlamydia trachomatis and gonorrhea; HIV infection; measles, influenza mortality, meningitis, and pertussis; clinical hepatitis A and B virus infections and infections caused by salmonella and campylobacter; Lyme disease; and tuberculosis.

Chronic disease prevention and control

One out of three Wisconsinites will develop cancer during their lifetime. Cardiovascular disease, including coronary heart disease and stroke, accounts for more deaths, disabilities, hospitalizations and health care expenditures than any other category of illness.

The public health agenda includes specific goals for the prevention and control of certain chronic diseases. The agenda endorses increased screening to reduce the incidence of breast, cervical and colorectal cancer and malignant melanoma; the reduction of risks factors to reduce the morbidity and mortality from cardiovascular disease; the reduction of diabetes mortality and end-stage kidney disease; improved community support for elderly persons with chronic disease or irreversible dementia; and the reduction of oral disease through fluoridation.

"They did it again – not a word in the weather report about an ice age."

Injury prevention

Motor vehicle accidents are the leading cause of spinal cord injuries, brain injuries, pelvic fractures and severe facial injuries. In Wisconsin, highway crashes resulted in 61,500 injuries during 1987 and 58,925 in 1988.

From 1981 to 1984, the average death rate from fire and burns in Wisconsin was 1.8 per 100,000. In Milwaukee County, however, the rate was 2.2 per 100,000. In 1986, 212 children under the age of six were hospitalized for burns.

Suicide and homicide are the second and fourth ranked cause of Wisconsin injury death respectively. In the US occupational injuries account for more than 20% of all injury related deaths and 40% of all injuries. On average, there are 62 fatal farm injuries in Wisconsin each year and 111 persons drown.

The public health agenda seeks to reduce morbidity and mortality associated with intentional and unintentional accidents. The agenda also notes that while health data report external causes of violent death, cause-specific injury morbidity data are uniformly poor and hamper the design of local prevention programs. One specific agenda implementation step recommends is the use of E-codes by all hospitals and ambulatory medical facilities.

Environmental health

In 1988, 427 toxic and hazardous incidents were reported to the Division of Emergency Government compared to 289 in 1987. There were 27 outbreaks of food and waterborne disease reported in 1988. During that year, 5,882 cases of amebiasis, campylobacter, giardia, hepatitis A, salmonella, shigella and yersima were reported.

The agenda addresses four areas of environmental health: drinking water and ground water contamination, ambient and indoor air pollution, hazardous waste disposal and toxic substances and exposures. The agenda establishes goals for reducing work site exposures to contaminants, childhood blood lead levels, indoor radon levels, and ingestion of naturally occurring radionuclides. The establishment of an environmental sentinel disease surveillance system and the improvement of the identification of and response to all episodes of environmental contamination are also recommended.

Reproductive and perinatal health

Wisconsin's infant mortality rate has shown a downward trend since 1970–16.9 infant deaths per 1000 live births in 1970 to 8.6 in 1987. Among state blacks, however the 1987 rate was 17.3 infant deaths per 1000 live births, and 20.7 among American Indians. The rate of SIDS among American Indians in the state is twice that among blacks and three times that among whites. In 1987, 5.4% of the state's infants were born at low birth weight with higher rates in the counties of Menominee, Milwaukee, Forest, Racine and Washburn.

One of the specific goals of the public health agenda is the reduction of the state's rate of infant death to no more than 9 deaths per 1000 live births within any county, racial/ethnic or age group by the year 2000. It also seeks to increase to 90% the proportion of women receiving prenatal care during the first trimester of pregnancy; to improve the reporting of congenital anomalies as an underlying cause of pregnancy loss; to ensure timely assessment of genetic problems; and to increase the proportion of women who abstain from drugs and alcohol during pregnancy.

Infant and child health

Injury has replaced infectious disease as the most serious threat to the health of children. For every Wisconsin child who dies of injury, 45 more are admitted to a hospital, and another 1300 require emergency room treatment. There are 19 reported cases of child abuse per 1000 children in the state. Between 1985 and 1986, the reported deaths attributable to child abuse rose from 10 to 15.

The public health agenda promotes the provision of primary health care and optimal nutritional status for all children. It sets forth specific goals for the reduction of injuries to children, communicable diseases, child abuse and neglect.

Adolescent health

Adolescents as a whole are physically healthy but they under-use the health care system and seek care sporadically. Teens are reported to have the lowest physician rate of any group although they are at significant risk of unintentional pregnancy, drug and alcohol abuse, depression and other psychological problems. The public health agenda targets the provision of comprehensive community-based health care programs for adolescents. It seeks the promotion of comprehensive primary care; pregnancy prevention; the reduction of sexually transmitted disease and AIDS; the prevention of substance abuse, unintentional and intentional injury; the promotion of mental health, physical activity and fitness, and nutrition.

Continued on next page

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

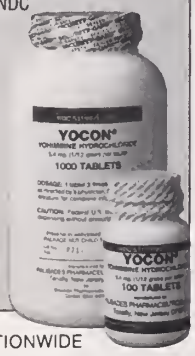
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Goals for 2000

The goals of the public health agenda for the year 2000 are extensive and ambitious viewed as a whole. Dr Scheckler, however, gave the agenda an individual's perspective when he summarized at the Wausau conference:

> What is our charge? To incorporate a prevention ethic into our own approach to life. Do you smoke? Do you wear a seatbelt every time you drive? Do you use alcohol as a drug? What is your diet like? Do you exercise regularly? And how about safe sex? What immunizations do you need? To incorporate a prevention ethic into your family, into those you love, at your place of work. To demonstrate leadership among our peers. To support public health and public funding for public health. To help the media articulate the problem and the solution of public health. To personalize it, make it real, make it believable. To develop good information and creatively use available resources, and to understand how to set priorities, relative risk, supportive surveillance and analysis. To develop new information, better screening techniques, better ways to modify behavior, better ways to integrate new knowledge into practice. To select areas within the agenda on which you may realistically make a contribution and then work for their achievement.

Dr Scheckler issued a final charge to the state Division of Health: "..not to direct but to teach, encourage, cajole and help" the citizens of the state of Wisconsin meet the goals of better health by the year 2000.

Meanwhile, the SMS Board of Directors has endorsed the primary objectives of the public health agenda and a number of SMS committees are reviewing the specific implementation steps of the agenda to determine the appropriate course for SMS involvement.❑

Public health

Childhood lead exposure in Wisconsin in 1990

Joseph Schirmer, MS, Henry Anderson, MD, and Dan E. Peterson, MD, Madison

On September 13, 1990, a 2-year-old boy from Waukesha died as a result of lead poisoning. His blood lead was 134 micrograms per deciliter (ug/dl) as a result of ingesting lead paint in his residence. Despite the publicity generated by this child's death, the major public health threat from lead exposure is characterized by undiagnosed, asymptomatic blood lead elevations which result in subtle but permanent neurological damage.[1,2] To identify other possible cases of lead poisoning, we searched the Wisconsin Office of Health Care Information's continuous hospital discharge system and identified 31 pediatric hospitalizations involving lead poisoning during the first three quarters of 1989. There are an estimated 36,000 children at high risk for lead poisoning in Wisconsin, but less than one third of these are now being evaluated through routine screening. In 1989, 880 Wisconsin children were reported to the Wisconsin Division of Health with blood lead values above 25 ug/dl, the value set by the Centers of Disease Control (CDC) as defining lead poisoning. Because of recent evidence demonstrating permanent neurological damage to children as a result of blood lead levels below 25 ug/dl,[3] the CDC is expected to recommend that the definition of an elevated blood lead level be lowered to 15 ug/dl within the next year.[4] The American Academy of Pediatricians recommends that all preschool children should be screened for lead absorption.[5]

Background

Although knowledge of the toxic nature of lead is centuries old, lead remains a widely used industrial metal. Battery manufacturing consumes the majority of the 1.5 million tons of lead used per year in the US.[6] Other uses include gasoline additives, pigments, ammunition, sheet metal and alloys. Forty to 50% of current production is recycled.[7] The national average blood lead value has declined since 1976. This decline may have been associated with federal regulatory initiatives, especially to reduce lead in gasoline[8] (Fig). Since the lead content of gasoline has been reduced, lead in paint now presents the major source of environmental lead exposure to children. Lead paint is common, it is often highly concentrated and it can be easily accessible to children, both as paint chips and as dust.

Continued on page 33

This Is How We Helped Change Medicare Legislation.

How Do You Tell Someone On Medicare She's An "Expenditure Target"?

Right now in Washington, a Congressional committee is toying with a new idea.

It's a system of explicit "expenditure targets" for the Medicare program.

The aim of this idea is to cut expenses. The result is that it will cut care.

What it amounts to is nothing less than an elaborate dis-incentive for treatment.

Instead of assuring access to vital health care services, this plan will accomplish the exact opposite. It will lead to the rationing of care.

The system calls for a national yearly target for spending on vital health care services. And after the target amounts are reached, the services would have to be reduced. This would be a disaster for older people.

Originally, Medicare was a golden promise that was made to all Americans. We ask the Congress to keep the faith of that promise.

American Medical Association

Thanks to AMA efforts on your behalf, House and Senate negotiators recently agreed to significant changes in the Medicare program.

These improvements, for both physicians and patients, were in marked contrast to earlier proposals called "Expenditure Targets." The AMA felt strongly that Expenditure Targets would have resulted in spending caps for physicians and rationing of care for their Medicare patients.

The AMA believes that this new approach developed by the Senate Finance Committee is more in line with our goal of improving health care services for all Americans.

We also believe this change in Medicare legislation is beneficial for our member physicians.

American Medical Association

Lead affects red blood production and the neurological, renal and reproductive systems. Environmental lead presents a particular risk to children because of three factors: ingestion, absorption and sensitivity.

Ingestion. Lead dust and paint chips are both important sources of lead. Paint chips containing lead are considered to be the major source for children with extremely high blood lead levels, while dust is a source for the more common, moderately elevated lead doses.[9] One popular misconception about childhood lead exposure is that lead problems are primarily caused by abnormal "pica" behavior. Pica, eating non-food materials, is a risk factor, but it need not be present for children to have elevated blood lead levels. For example, in a study of children with blood lead levels of 16-22 ug/dl, pica behavior had no relation to blood lead, whereas lead dust concentrations on children's hands were found to significantly contribute to blood lead levels.[10]

Children ingest more lead dust than adults. An average 2-year-old consumes 21 ug of lead dust per day, while adults consume 4.5 ug per day.[11] Normal, developmentally appropriate toddlers are curious; they explore their environment with all their senses, typically using considerable hand to mouth activity. Where the environment contains lead, children will get lead dust on their hands which can then enter their mouths through normal hand to mouth activity. Lead dust is a more insidious hazard than paint chips because dust is less visible and because lead absorption is inversely proportional to particle size, so that smaller particles are more efficiently absorbed into the bloodstream.

Absorption. Children absorb 50% of lead ingested, while adults absorb 10-15%.[12]

Sensitivity. Children's nervous systems are still developing and, as such, are more vulnerable to the toxic effects of lead. Young children with moderately elevated blood lead experience a variety of learning difficulties which can be seen in first and second grade and which persist even through high school. For example, first and second grade children with mean blood lead of 34 ug/dl were found 11 years later to be at 7.4 times higher risk of dropping out of high school than a similar group whose childhood mean blood lead was 24 ug/dl.[13]

Lead in Wisconsin

Nationally, 17% of children in urban areas are estimated to have blood lead levels greater than 15 ug/dl, a level associated with adverse medical effects.[14] In Wisconsin's 14 largest cities, 36,000 children are estimated to be at high risk for lead poisoning based on three risk factors: age under 7 years; residence in housing built before 1950 (when lead paint was more commonly used); and annual family income of below $15,000. Low income is a risk factor since poor people are more likely to live in older housing in which painted surfaces are deteriorating, making the lead more accessible. The number of Wisconsin children at risk in smaller rural communities is unknown.

Wisconsin Chapter 151 requires reporting of all blood lead tests over 25 ug/dl. With support from the Centers for Disease Control, Public Health Service, and the Agency for Toxic Substances and Disease Registry and the cooperation of many laboratories, the Wisconsin Division of Health has, since 1987, initiated a laboratory-based surveillance system for elevated blood lead. Currently, however, less than one third of the estimated 36,000 children at high risk for lead poisoning in Wisconsin's 14 largest cities are screened each year.

Local government provides most of the initiative and funding for lead poisoning prevention programs in Wisconsin. Of the estimated 36,000 children at high risk for lead poisoning in Wisconsin's 14 major urban areas, half live in Milwaukee. The Milwaukee Health Department (MHD) has shown an especially strong commitment to identify, evaluate and control environmental lead hazards. The MHD pioneered outpatient treatment protocols in the 1970s and currently MHD is developing new lead abatement procedures. In 1989, more than 9,000 screening tests were conducted on Milwaukee children, more than 80% of all screening tests

Continued on next page

Series coordinators
The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, Wisconsin Division of Health are coordinating this series for the *Wisconsin Medical Journal.* Physicians wishing more information on laboratory testing or environmental evaluation of homes can contact their local health agency or the Wisconsin Division of Health at (608) 266-5885.

Schirmer is a public health educator-epidemiologist with the Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Dr Anderson is chief of the Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Dr. Peterson is an EIS officer assigned to the Division of Health from the Centers for Disease Control. The Division of Health's environmental disease surveillance program is partially funded through a grant from the Centers for Disease Control, Public Health Service, National Institute for Occupational Safety and Health, and in cooperation with the Agency for Toxic Substances and Disease Registry. Reprint requests to: Henry Anderson, MD, Wisconsin Division of Health, PO Box 309, Madison, Wisconsin 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin

conducted last year in Wisconsin. In 1989, MHD staff inspected 938 housing units and conducted more than 2,600 home visits. The total estimated cost to run this program for 1989 was $416,000.

The Wisconsin biennial budget adopted for 1989-1991 appropriated $49,500 for the purchase of instruments to screen children for lead at WIC clinics and $74,700 for lead paint detection instruments to go to local public health agencies. The Department of Health and Social Services (DHSS) purchased and distributed these instruments to the eight cities with largest number of children under 7 years old living in housing built before 1950: Milwaukee; Racine; Kenosha; West Allis; Sheboygan; Green Bay; Madison; and Appleton. Given their limited resources, local agencies are struggling to carry out these responsibilities. Certified HealthCheck providers (including some local health agencies) may be reimbursed by Medicaid for testing Medicaid eligible children for lead. Recently proposed changes may also require all Medicaid-eligible children to be screened for lead.

Public health agenda

The Public Health Agenda for Wisconsin identified lead as a major environmental hazard and set forth three steps towards the goal of reducing the number of children with elevated blood lead by 80% by the year 2000.

- By 1995, local public health agencies (LPHAs) should screen all children in high risk areas for high blood lead levels.
- By 1995, the Legislature should require that real estate buyers be informed of the presence of lead-based paint in housing environments.
- By 2000, the DHSS, the UW-Cooperative Extension and LPHAs should conduct public campaigns through lead screening centers to educate at least 70% of adults that the home is the most important source of potential lead exposure for children.

Summary

It will take the cooperation of many people to address the issue of lead poisoning. The recent death has dramatized the problem of high dose exposures. But a larger challenge is posed by the fact that most preschool children in Wisconsin are not screened for lead and as a result many asymptomatic children without signs of pica behavior will experience subtle neurological damage as a result of low to moderate elevations of lead in blood. Because many of these cases occur in children without recognized pica behavior, doctors need to expand screening, especially during well child visits, to identify children with elevated blood lead levels. Additionally, the public health community and property owners need to evaluate and control sources of lead. Major efforts

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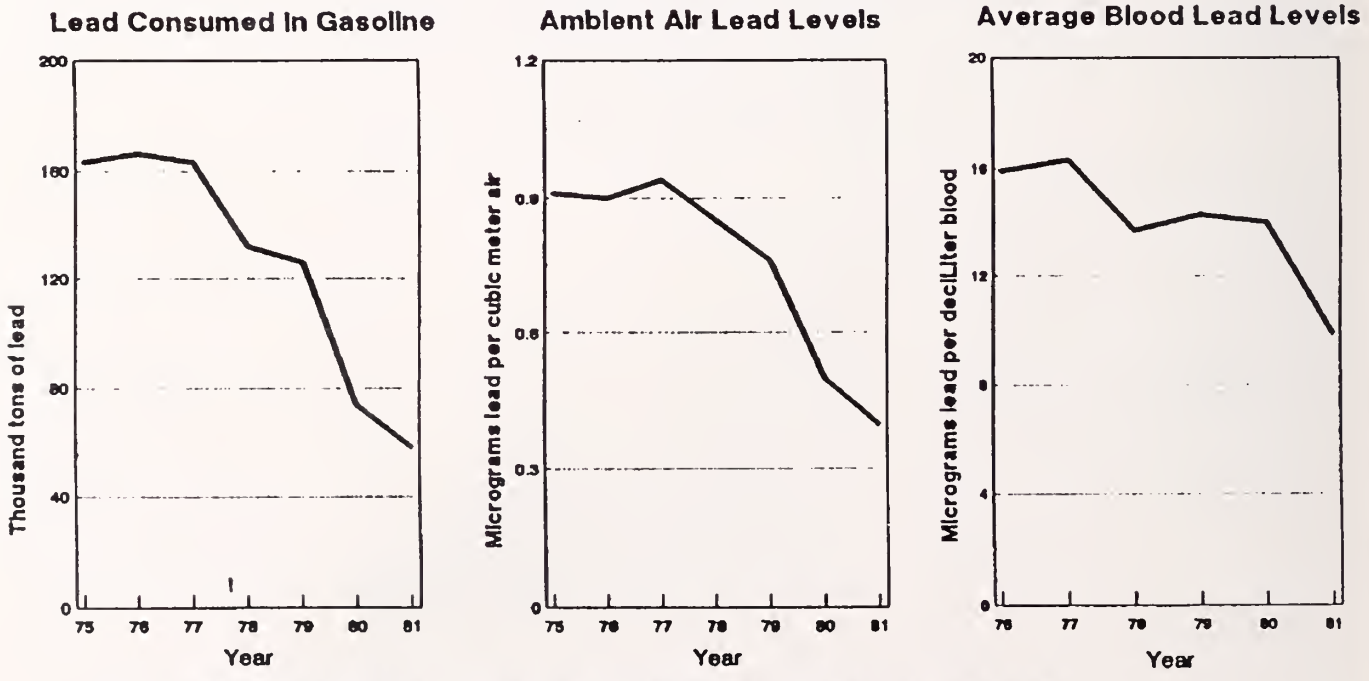

Fig–Lead trends in the United States: gasoline, air, and blood.

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are needed to address the lead hazards which now impair hundreds of Wisconsin children each year.

Acknowledgements

The authors appreciate the assistance of Patrick Remington, MD, Jane Brelis Schirmer, RN, and Larry Hanrahan, MS, in reviewing drafts of this manuscript. We also appreciate the assistance of Paula Lantz, MS, who created the figure for this text and Linda Haskins, BS, who evaluated data from the Office of Health Care Information.

References

1. American Academy of Pediatrics. Statement on childhood lead poisoning. *Pediatrics.* 1987;79:457.
2. Agency for Toxic Substances and Disease Registry. *The nature and extent of lead poisoning in children in the United States: A report to Congress.* US Department of Health and Social Services, 1988;DHSS document no. 99-2966.
3. World Health Organization. *Air quality guidelines for Europe.* Copenhagen, World Health Organization, Regional Office for Europe, 1987;242-261.3.
4. Public Health Foundation. Laboratories seek new technology to screen for lead poisoning. *Public Health Macroview.* 1990;3:1.
5. American Academy of Pediatricians. Statement on childhood lead poisoning. *Pediatrics.* 1987;74:463.
6. Goble R, Hattis D, Ballew M, et al. *Implementation of the occupational lead exposure standard in preventing illness and injury in the workplace.* Office of Technology Assessment, 1983;2C2-21.
7. US Environmental Protection Agency. *Air quality for lead.* 1986;I:1-15.
8. US Environmental Protection Agency. *Costs and benefits of reducing lead in gasoline: final regulatory impact analysis.* 1985. Washington, DC. Office of Policy Planning and Evaluation (Schwartz J, Pitcher H, Levin R, Ostro B, Nicholas AL) EPA report No EPA-230/05-85-006.
9. American Academy of Pediatrics. Statement on childhood lead poisoning. *Pediatrics.* 1987;79:3:457-465.
10. Gallacher JEJ, Elwood PC, Phillips KM, et al. Relation of pica blood lead in areas of differing lead exposure. *Archives of Diseases in Childhood.* 1984;59:40-44.
11. Environmental Protection Agency. *Air quality criteria for lead.* 1986;II:Table 7-19.
12. US Environmental Protection Agency. *Air quality criteria for lead.* 1986;III:10-61.
13. Needleman HL, Schell A, Bellinger D, et al. The long term effects of exposure to low doses of lead in childhood: An 11 year follow-up. *New England Journal of Medicine.* 1990;322:83-88.
14. Agency for Toxic Substances and Disease Registry. *The nature and extent of lead poisoning in the US: A Report to Congress.* Atlanta, US Department of Health and Social Services, Public Health Service, 1988;DHSS document no. 99-2966.❑

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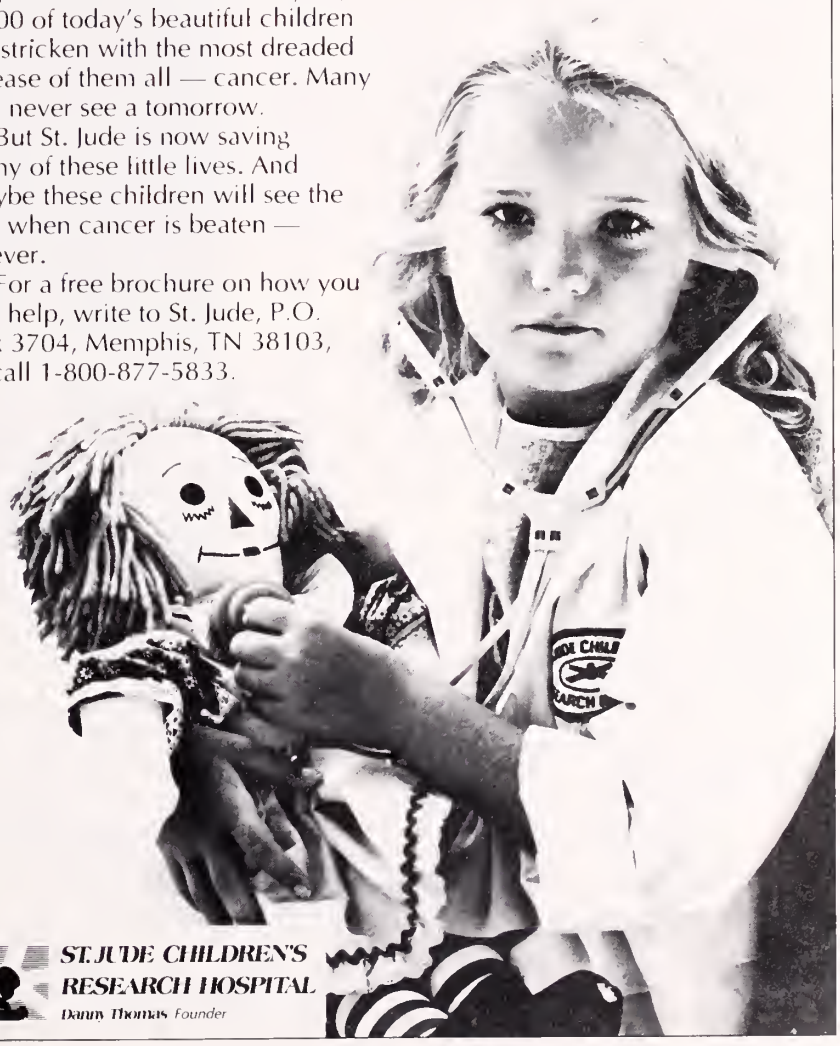

ST. JUDE CHILDREN'S RESEARCH HOSPITAL
Danny Thomas Founder

Life May Begin At Forty, But Heart Disease Can Begin At Four.

Photographed by Bodi

Contrary to popular opinion, heart disease doesn't happen only to people over 65. 175,000 people under 65 die from it each year. And in the last few years, evidence points to the fact that heart disease may even begin in early childhood.

A study of more than 8,000 children lasting 15 years suggests that it's prudent to encourage kids in the right eating habits.

The fact is, a diet low in saturated fat and cholesterol can lower a major risk for heart disease in adults, and may very well affect children in the same way. And that kind of diet is as easy to live with in the short run as it is in the long.

To find out more, just call or write your local American Heart Association.

We'll send you a free booklet that will show you how to help your child grow into a good-hearted adult.

Your Life Is In Your Hands.

American Heart Association

This space provided as a public service.

Physician briefs

The * indicates a member of the SMS.

Peter B. Taylor, MD,* of Fond du Lac, has begun a medical and surgical ophthalmology practice at the office of Brian Hammes, MD. Dr Taylor completed his undergraduate education at Emory University and received his medical degree from the University of Miami School of Medicine. He served his medical internship at Mount Sinai Hospital in Miami Beach. He completed his ophthalmology residency at the Medical College of Wisconsin.

Thomas Bartow, MD,* of Marshfield, recently joined the staff of the Marshfield Clinic. A rheumatologist, Dr Bartow received his medical degree from the State University of New York-Stony Brook School of Medicine. He served his residency in internal medicine at Rush Medical College-Presbyterian-St Luke's Hospital in Chicago. Dr Bartow completed his fellowship in rheumatology at Johns Hopkins University in Baltimore.

Kim Peterson, MD, of Belleville, recently joined Physicians Plus Medical Group. A geriatrician, Dr Peterson is a specialist in the care and treatment of older persons who have problems associated with aging. Dr Peterson has also been appointed medical director at Meriter Retirement Services and provides medical direction and geriatric consultation for the Methodist Retirement Center, ElderHouse and the Methodist Health Center.

James C. Brandes, MD,* of Greendale, has been appointed assistant professor of medicine at the Medical College of Wisconsin. A kidney specialist, Dr Brandes graduated from the Medical College of Wisconsin in 1985. Dr Brandes has been honored as outstanding resident during his internal medicine residency, and in 1989, was honored as outstanding teaching fellow while serving a nephrology internship.

Thomas S. Cunningham, MD,* of Janesville, has recently joined the Janesville Medical Center. An internist, Dr Cunningham is a graduate of the University of Health Sciences, College of Osteopathic Medicine in Kansas City. Dr Cunningham completed a residency in internal medicine at the University of Missouri-Kansas City.

Paul L. Lindholm, MD,* of Marshfield, was recently elected area medical director of the American Cancer Society Wisconsin Division Board of Directors. As a member of the board, Dr Lindholm will assist in determining programs and policies of the Wisconsin division. Dr Lindholm will also serve on one or more standing committees.

Russell Butkiewicz, MD,* of Ogdensburg, has recently joined the Waupaca Family Medicine Associates and the Riverside Medical Center. A family practitioner, Dr Butkiewicz graduated from the University of Wisconsin Medical School and com-

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Continued from preceding page
pleted his internship and residency at St Mary's Hospital and the University Hospital and Clinic.

Joan Harrington, MD, and **Donald Leright, MD,** of Platteville, have established a podiatry practice in Platteville. Dr Harrington received her medical degree from the Dr William Scholl College of Podiatric Medicine in Chicago. She completed a surgical residency at Leyden Community Hospital in Northlake, Ill. Dr Leright also graduated from the Dr William Scholl College of Podiatric Medicine. He completed a surgical residency at Windom Area Hospital in Windom, Minn.

Peter W. Burns, MD,* of Rhinelander, recently joined the Rhinelander Medical Center. An obstetrician and gynecologist, Dr Burns earned his medical degree from the University of Wisconsin Medical School. He completed his residency in obstetrics and gynecology at the University of Wisconsin Hospital.

Richard K. Karr, MD,* of Grafton, recently began a practice located in the Grafton Professional Building. Dr Karr received his medical degree and completed his orthopaedic surgery residency at the Medical College of Wisconsin.

Wallace Irwin, MD,* of Lodi, was recently named "Citizen of the Year for 1990," by the Lodi Chamber of Commerce. Dr Irwin received his medical degree from the University of Wisconsin Medical School and completed his internship at Cincinnati General Hospital. From 1965 until 1980, Dr Irwin was Lodi's only physician. He retired in 1986.

George D. Geanon, MD,* of Milwaukee, has recently been appointed assistant professor of obstetrics and gynecology at the Medical College of Wisconsin. Dr Geanon currently practices at the Milwaukee County Medical Complex. Dr Geanon received his medical degree from the Loyola University Stritch School of Medicine and completed his residency in obstetrics and gynecology at the Milwaukee County Medical Complex.❑

County society news

Brown. Eighty-four members and guests were present at the November meeting to hear David G. Benzer, MD, of Wauwatosa, speak on the "Impaired Physician Program." Officers elected for 1991 are MDs Jeremy R. Green, president; James V. Lacey, president elect; Bruce C. Bressler, past president; Michael Medich, secretary, and Roger C. Wargin, Treasurer.

Dane. The following physicians were accepted to membership in the society: Ezad N. Ahmad, MD; Clifford J. Anderson, MD; Candye R. Andrus, MD; Kenneth T. Bastin, MD; Russell N. Beckhardt, MD; George D. Birmingham, MD; Lon A. Blaser, DO; David E. Blume, MD; Brian P. Brocker, MD; Darrel S. Brodke, MD;James V. Bruno, MD; Mark R. Burge, MD; Daniel F. Cannon, MD; William H. Chickering, MD; Leesa I. Comparin, MD; David A. Cook, MD; David C. Crabtree, MD; William I. Douglas, MD; Zach M. Ellis, MD; Mirhassan Farivar-Mohseni, MD; Brent A. Feller, MD; James K. Fitzpatrick, MD; Dana S. Garrison, MD; Anestis N. Gianitsos, MD; David R. Greeley, MD; Bashar Hakim, MD; Hisham Hakim, MD; Hisanori Hasegawa, MD; Agha S. Khan, MD; Gregory S. Keeling, MD; Erin M. Kennedy, MD; Ann E. Kuhnen, MD; Karen L. Lawson, MD; Katherine T. Lewis, MD; Tesu T. Lin, MD; Philip E. Lund, MD; Melissa Meredith, MD; Joel D. Miller, DO; Casey M. Muehle, MD; Eugene A. Nwosu, MD; Emilia Phillips, MD; Ronald L. Rains, MD; Paul D. Reynen, MD; Rey Rodriguez, MD; Donene A. Rowe, MD; Benjamin T. Schmidt, MD; Bryson S. Smith, MD; Thomas D. Stamos, MD; Melissa M. Stiles, MD; Anthony K. Strigenz, MD; Thomas I. Strinden, MD; Mark G. Timmerman, MD; Charles E. Truthan, DO; Michael J. Tullis, MD; Eric M. Westerman, DO; and Gaiser J. Yusuf, MD.

Marathon. Mahmood H. Al-Wathiqui, MD; Zlatko Knezevic, MD; James D. Lincer, MD; Gerald Edelman, MD; and Mark A. Richetto, MD, have been accepted to membership in the society.

Milwaukee. New member of the society are James V. Bruno, MD; Stephen R. Hazelrigg, MD; Martin W. Knippel, MD; Falies A. Munas, MD; Suzette Peltier, MD; Daniel C. Tanty, MD; and Allan F. Van Nostrand, MD.

Vernon. Guest speakers at the county medical society were Robert M. Green, MD, of La Crosse, chief of the Western Wisconsin Heart Institute, and Kay Jewell, MD, medical director, WPS Medicare, of Madison. Dr Green spoke on the "Pros and Cons of Angioplasty," and Dr Jewell spoke on "Recent Changes in Medicare." Michael Kirby, associate director of the SMS Division of Public Affairs and Ms Kay Bassett from Marion Laboratories were present. At the business meeting, Mark H. Andrew, MD, of Viroqua, was re-elected president of the society for 1991; Timothy J. Devitt, MD, of Soldiers Grove, re-elected vice president, and Rolando Macasaet, MD, of Viroqua, re-elected secretary-treasurer. The delegate is Dr Devitt with the alternate delegate being Dr Andrew. There were 43 members and guests present.

Washington. Officers for the year 1991 recently were elected at the county medical society meet. They are Uday V. Gupte, MD, of Hartford, president; Jaffery C. Koszczuk, DO, of West Bend, president elect, and Peter L. Cornelius, MD, of West Bend, secretary-treasurer.

Winnebago: Mr. T. Michael Bolger, president of the Medical College of Wisconsin, was the guest speaker at the November meeting of the society. His topic was "Medical education into the 21st century." Forty-one members were present. The following physicians were accepted to membership: Paul D. Dernbach, MD; Maurice W. Chung, MD; Forrest Bates, MD; Russell S. Bell, MD; Raymond F. Georgen, MD; Robert S. Schmus, MD; Eileen C. Fisher, MD; Wayne J. Rusin, MD; and David C. King, MD. ❑

Obituaries

Lorne A. Campbell, Jr, MD, 79, of Clear Lake, died March 25, 1990, in Clear Lake. Dr Campbell was born April 21, 1910, in Clear Lake, and graduated from the University of Minnesota School of Medicine in 1938. His internship was served at Wayne County hospitals in Eloise, Mich. Dr Campbell was a member of the "50 Year Club" of the State Medical Society of Wisconsin and a member of the Polk County Medical Society and the AMA.

Sydney T. Gettelman, MD, 70, of Milwaukee, died May 7, 1990, in Milwaukee. Dr Gettelman was born Aug 26, 1919, in Milwaukee, and graduated from the University of Illinois College of Medicine. His internship was served at Lutheran Deaconess Hospital, Chicago, and his residency was completed at Oak Park Hospital, Oak Park, Illinois. Dr Gettelman served in the United States Army from 1950-1953. He was a member of The Medical Society of Milwaukee County, the SMS, and the AMA.

Abraham Melamed, MD, 75, of Fox Point, died Aug 12, 1990, in Fox Point. Dr Melamed was born Nov 19, 1914, in Chicago, graduated from the University of Illinois School of Medicine, and completed his internship at Mt Sinai Hospital in Milwaukee. His residencies were completed at Cook County Hospital, Chicago, and Mt Sinai Hospital in New York. Dr Melamed served as director of the Department of Radiology at Mt Sinai Hospital, Milwaukee; St Joseph's Community Hospital, West Bend, and Hartford Memorial Hospital before retiring in 1980. He was credited with bringing the installation of the first cobalt treatment machinery in the state, the first radiation treatment for cancer. He was a past president of the

Continued on next page

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑

Milwaukee Roentgen Ray Society. He was a member of the Washington County Medical Society, the SMS, and the AMA. Surviving are his widow, Hope; two daughters, Abby Johnson, of Berkeley, Calif, and Aggy Melamed, of Los Angeles; and one son, John, of Milwaukee.

John A. Smith, MD, 77, of Horicon, died Sept 14, 1990, in Humacao, Puerto Rico. Dr Smith was born March 17, 1913, in Reynoldsburg, Ohio, and graduated from Ohio State University School of Medicine. His residency was completed at Gorgas Hospital in the Canal Zone. From 1946 to 1976, Dr Smith was director of Ryder Hospital, Inc, in Humacao, Puerto Rico. This small mission hospital grew to become a complete medical center during his incumbency, as described in his book, "Ryder Hospital; an unfolding story of health care in Puerto Rico."
He became director of the Flyway Clinic, Dodge County, in 1978 and retired from there in 1984. He continued to be the medical director of the Dodge County Community Health Center in Juneau, until late in 1987. Dr Smith was a member of the Dodge County Medical Society, the SMS, and the AMA. Surviving are his widow, Virginia; three sons, John D., of Boulder, Colo; Dr Howard A., of Humacao, Puerto Rice, and Dwight H., of Ponce, Puerto Rico.

Lewis Danziger, MD, 82, of Milwaukee, died Sept 20, 1990, in Milwaukee. Dr Danziger was born Sept 21, 1907, in Philadelphia, and graduated from Johns Hopkins University Medical School. His internship was served at the Baltimore City Hospital, and his residency completed at Johns Hopkins Hospital. He was on the medical staff of St Michael's Hospital, Milwaukee, until his retirement. He was a member of the American Psychiatric Association, the Medical Society of Milwaukee County, the SMS, and the AMA. He is survived by his widow, Dorothy.

Maurice L. Whalen, MD, 84, of Bruce, died Oct 2, 1990, in Bruce. Dr Whalen was born Aug 21, 1906, in Hibbing, Minn, and graduated from the University of Minnesota Medical School. His internship was completed at St Luke's Hospital in Duluth, Minn. Dr Whalen practiced in Bruce for 42 years, retiring in 1974. For 19 years, Dr Whalen was a preceptor for students at the University of Wisconsin Medical School, Madison, and over the years 100 UW medical students stayed with him for periods of three months, learning about the life and duties of small town general practice. In 1974, he received the Max Fox Preceptorship Award from the UW Medical Alumni Association. In 1978 he received the Distinguished Service Award from Mt Senario College, Ladysmith, the highest non-academic award given by the college. Dr Whalen served on the Wisconsin Medical Examining Board. He was a member of the International College of Surgeons, the American Academy of Family Physicians, the Rusk County Medical Society, the SMS, and the AMA. Surviving are his widow, Florence; three sons, Michael, Thomas, and Gerald, of Eau Claire; and two daughters, Kathleen Smith, of Oshkosh, and Mary, of Eau Claire.

Thomas S. Josephson, MD, 53, of Madison, died Oct 7, 1990, in Madison. Dr Josephson was born June 21, 1937, in West Allis, and graduated from the University of Wisconsin Medical School. He served his internship at Wm Beaumont General Hospital, El Paso, Tex, and his residency at University Hospitals and Clinics, Madison. He was a member of the Dane County Medical Society, the SMS, and the AMA. He also was a member of the American Psychiatric Association and the Wisconsin Psychiatric Association. Surviving are his widow, Louise; and two sons, Ben and Thaddeus, both at home.

William G. Peterson, MD, 63, of Madison, died Oct 14, 1990, in Madison. Dr Peterson was born May 11, 1927, in Newark, New Jersey, and graduated from Creighton University Medical School, Omaha, Nebraska. His internship was served at Mercy Hospital, Buffalo, New York, and his neurological residency was completed at the University of Minnesota Hospitals in Minneapolis. Dr Peterson served in the United States Air Force from 1961-1963. He had been a faculty member of the University of Wisconsin Medical School from 1963 until 1967; and more recently had been a member of the Madison Neurological Center. He was a member of the American Academy of Neurology, the Dane County Medical Society, the SMS, and the AMA. Surviving are his widow, Jeanne; two daughters, Kathleen and Regina, of New York; and four sons, William and Thomas, of Madison; John, of Los Angeles, Calif, and Michael, of Boston, Mass.❑

Wisconsin Medical Journal

Instructions for authors

Authorship

Manuscripts are considered with the understanding that they have not been published previously and are not under consideration by another publication.

Each manuscript must be accompanied by a cover letter containing the following sentence: "In consideration of the *Wisconsin Medical Journal*'s taking action in reviewing and editing this submission, the author(s) hereby transfer(s), assign(s), or otherwise convey(s) all copyright ownership to the *WMJ* in the event that this work is published in the *WMJ*." All co-authors must sign the letter.

The cover letter must also designate one author as correspondent and provide a complete address and telephone number. All coauthors should have contributed to the study and manuscript preparation. They should be thoroughly familiar with the substance of the final manuscript and be able to defend its conclusions.

The *Journal* expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. All funding sources supporting the work should be routinely acknowledged on the title pages, as should all institutional or corporate affiliations of the authors.

Editing

All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style. Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

Manuscript preparation

- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
- Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.
- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
- Organization for scientific papers:

Abstract—150 words or less, stating the problem considered, methods, results and conclusions.

Methods—Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results—Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion—Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

References—Limit to 20. Authors are responsible for the accuracy and

completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

• Acknowledge all illustrations and tables taken from other publications, and submit written permission to reprint from the original publishers.

Style

• Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors*.

• Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")

• Authors are responsible for supplying the full and correct names of drugs. Use generic names of drugs, unless the specific trade name of a drug is directly relevant to the discussion. If the author so desires, brand names may be inserted in parentheses.

• Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.

Review process

Each scientific manuscript is reviewed by the medical editor and the members of the editorial board. The opinions of outside consultants may be sought at the medical editor's discretion. The medical editor has the final decision as to whether a scientific paper will be published.

Publication support

Authors of articles that are longer than 2 typeset pages (including tables or illustrations), or roughly 5 typewritten pages, may be asked by the editorial board to provide publication support in the amount of $100 per typeset page beyond the second. Such support is not mandatory and is not asked for until after a paper is accepted for publication. Provision of support helps defray the cost of publishing the *Journal* and is left to the conscience of each author.

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When you make a habit of choosing high-cholesterol foods, you're choosing a dangerous course. One that could lead to a high cholesterol level in your blood and eventually to a heart attack. Remember that the next time you browse through a menu. And place your order as though your life depended on it.

American Heart Association WE'RE FIGHTING FOR YOUR LIFE

This space provided as a public service.

Radiologist. A three-physician radiology group is seeking a fourth radiologist with experience and interest in interventional radiology. Dickinson County Hospitals is a progressive, 126-bed,two hospital system located in Iron Mountain, Michigan's Upper Peninsula. We have a service area population of over 45,000. Contact and/or send resume: Doctors Specht/ Shampo/Manzano, Radiology Department, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; ph 906-779-4565. 1-2/91

Family Practice. Physicians seeking a BE/ BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes, Anderson Memorial Hospital, Main St, Norway, MI 49870; ph 906-563-9243 or office 906-563-9255. 1-2/91

Opportunity for BC/BE family physician to join well-established physician in Christ-centered family practice. Newer offices located adjacent to hospital. A 1991 FP resident graduate would be welcome. Please contact Thomas R. Jensen, MD, 8800 West Lincoln Ave, West Allis, WI 53227; ph 414-321-7373. 1-2/91

Emergency physician, Milwaukee. Excellent opportunity for BC/BP emergency or otherwise qualified physician to join a stable, well-established, board certified fee-for-service group staffing a 560-bed tertiary care teaching hospital's ED. 35,000 visits annually. Excellent specialty back-up. Peak double coverage on a daily basis. Salary starts at $130,000 per year for 40-hour work week, plus paid malpractice coverage and four weeks paid vacation/CME in first year. Exceptional benefits including paid vacation that grows to 12 weeks per year. Equitable partnership available. Send CV to I. Gailans, MD, FACEP 5000 W. Chambers St, Milwaukee, WI 53210; ph 414-447-2171. 1-2/91

General surgeon BE/BC to join another general surgeon and eight FPs in a multi-specialty clinic in Wisconsin's heartland. Referral area of 35,000. State of the art 100-bed acute care facility with three major and two minor ORs. Comprehensive financial package for the candidate and family. Early partnership available. Contact Dept 631 in care of the Journal. p1/91

West Bend, Wisconsin. Seeking full-time and part-time emergency physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided, benefit package, and incentive bonus plan available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p1/91

Lake Winnebago, Wisconsin area: Seeking director, full-time and part-time emergency physicians for low volume 60-bed hospital. Attractive compensation, full malpractice insurance coverage and benefit package available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 36, Traverse City, MI 49684; 1-800-253-1795 in Michigan 1-800-632-3496. p1/91

Antigo, Wisconsin: Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation andl paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p1/91

Kewaunee, Wisconsin: Seeking part-time emergency physicians for low volume facility located 1/2 hour east of Green Bay. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 South Airport Rd, Rm 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p1/91

Medford, Wisconsin: Seeking director, full-time, and part-time emergency physicians for moderate volume facility located in northern Wisconsin. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p1/91

Family practice. Crystal Falls, in Central Southern Upper Peninsula of Michigan, is seeking a BE/BC family practice physician. The physician will have the option of joining an existing practice or setting up a hospital-sponsored practice. Service area of 8,000. Contact H. B. Purdy, CEO, Crystal Falls Community Hospital, Michigan Ave, & Third St, Crystal Falls, MI 49920, or phone; office 906-875-4144 or home 906-875-4145. 1-3/91

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary $30,000 plus paid health, life, malpractice, 401K (total package worth in excess of $40,000). Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

The Medical-Surgical Clinic has an immediate opening for family practice or urgent care physician(s) to staff this southside, multi-specialty clinic's Extended Hours Service from either 2 - 10 PM or 5 - 10 PM, Monday thru Friday. Physicians could share this position or one physician could have full responsibility. Clinic will pay an hourly wage. Fringe benefits are available. Send CV to: The Medical Surgical Clinic, SC, Attn: Marc R. Caine, MD, Medical Director, 2400 W. Lincoln Ave, Milwaukee, WI 53215. 1/91

Internal medicine--Wisconsin Rapids. Eleven-physician group (all certified) adding 5th general internist; growing, diverse practice; modern hospital - 8 bed ICU–excellent diagnostic services; competitive income, benefits; 40,000 metro population on Wisconsin River in central Wisconsin. Quality family environment. Contact: Phil Kelbe, 1110 N Third St, Suite 356, Milwaukee, WI 53203; ph 414-347-7841. p12/90;1/91

RATES: 55 cents per word, with a minimum charge of $25 per ad.

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SEND TO: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Physicians Exchange

Continued

Physicians--Come to sunny Arizona. Enjoy the dual benefit of Tucson's ideal climate and being a part of one of the most respected group practices in the southwest. Our 50-physician multi-specialty group practice has been in Tucson since 1974. We are providers for HMOs and we are expanding our fee-for-service practice. We are seeking to expand in the specialties of internal medicine, OB/GYN, family practice, and pulmonary. Salaries and benefits are competitive. Send resume with salary requirements to: Neil West, MD, GHMA Medical Centers, PO Box 40550, Tucson, AZ 85717. Principals only–no phone calls please. 12/90;1/91

Internal medicine/family practice physician needed to join an established, busy multi-specialty clinic in southern Wisconsin. Academic affiliation. Clinic is located near many recreational facilities and two large cities. Contact: David B. Gattuso, MD, 608-884-3417. 12/90;1/91

Lower Wisconsin River family practice or general practice, full service clinic. Over $300,000 gross. Associate wanted. Salary or partnership available. Send CV or call Muscoda Medicenter, Steven M. Liss, MD, 525 N Wisconsin Ave, Muscoda, WI 53573; ph 608-739-3192. 12/90;1-2/91

MILWAUKEE SUBURBS

Outstanding is far too mild a statement to describe these FAMILY PRACTICE opportunities—located in the most attractive suburbs of Milwaukee. Four different sites available–something for everyone. For more information contact Bob Strzelczyk at 1-800-243-4353 or write:

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Family practice opportunity on the shores of beautiful Lake Michigan. The Two Rivers Clinic, Ltd., an 11-physician multi-specialty group is seeking BC/BE physician to join four family practice associates. Exceptional quality of life and outstanding recreational area for family. New facility within walking distance of hospital and nursing home. Excellent income potential. Send CV or contact Jack Gospodarek, Executive Director, 2219 Garfield Street, Two Rivers, Wisconsin collect 414-739-2281.

Two Rivers Clinic, Ltd.
2219 Garfield St., Two Rivers, WI 54241
1-3/91

Family practice or internal medicine. Riverview Clinic, a 60-member multi-specialty facility has a position available at our regional clinic in Delavan. No night call or hospitalization responsibility. Excellent lifestyle and benefits in beautiful southern Wisconsin. Send CV to Stan Gruhn, MD, Riverview Clinic, 580 N Washington St, Janesville, WI 53545. p12/90;1-5/91

Lake Michigan Shore. BC/BE FP, IM, and OB/GYN to join 19-physician multi-specialty group adjacent to expanding hospital on Lake Michigan across from Door County. No prepaid medicine. Send CV or call Gerard De Bruin, Administrator, Marinette-Menominee Clinic, 1510 Main St, Marinette, WI 54143; ph 715-735-7421. p12/90;1-2/91

BC/BE general internist (with or without subspecialty interest) to join a busy and expanding four (4) physician internist group in Oshkosh, Wisconsin. Guaranteed salary and production bonus. Excellent benefits and income potential. Send CV to Dept 630 in care of the Journal. 12/90;1-3/91

Family practitioner BC/BE, to join a progressive 13-physician group practice in July 1990. Rural college town 30 miles from St Paul, Minnesota, with community hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701 or 612-436-8809. 3tfn/90

Beloit Clinic, SC, an expanding 45-physician, multi-specialty group in southern Wisconsin college town, in southern Wisconsin college town, is seeking an internist, a pulmonologist, a rheumatologist, an OB/GYN, an ophthalmologist, a general (vascular) surgeon, and a plastic surgeon. Guaranteed salary with incentive, plus excellent fringe benefits. Send CV to James F. Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 1-3/91

INTERNAL MEDICINE

Milwaukee is the location for this multispecialty practice. This 35 physician group includes 11 internists presently and seeks an additional associate. For further information please contact Gary Williams 800/544-6728.

JONAS

1/91

MD needed. Full or part-time position available at women's health center providing abortions in metropolitan Milwaukee area. Salary and hours are negotiable. Contact Chris Gorski at 414-442-2400. 12/90;1-5/91

Dermatologist, psychiatrist, allergist, internal medicine, family practice. A progressive, 126-bed, two-hospital system is seeking the above specialties to establish practice in the Iron Mountain area of Michigan's upper peninsula. Must be BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, C02 laser, and a fully-staffed special diagnostic department. Contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; ph 906-779-4500. 12/90;1/91

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full-time staff physician. Approximately 10,000 annual visits. Compensation to be negotiated. Pleasant area in which to live, near Devil's Lake and the Baraboo Hills. Also, Madison nearby. Contact: Thomas Warwick, Executive vice President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; 608-356-5561, ext 492. 11tfn/89

Madison, Wisconsin. Family practice physician to join our dynamic multi-specialty clinic. Guaranteed salary, profit-sharing, excellent fringe benefit package. Send CV to: L.C. Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Road, Madison, WI 53715. An Equal Opportunity/Affirmative Action Employer. 1tfn/90

New Physicians for Wisconsin
is seeking

- Family Physicians
- Internists

and many other specialties

Contact: Karen M. Paulson
UW Office of Rural Health
5721 Odana Road
Madison, WI 53719

608-273-5964 COLLECT
7-12/90;1-6/91

Physicians Exchange

Continued

Internal medicine and infectious disease. Multi-specialty group seeking BC/BE general internist and infectious disease specialist to join 19-member department (5 general internists and 14 subspecialists including one infectious disease specialist). Clinic is physically attached to a 206-bed hospital. Two state universities and private liberal arts college enhance the cultural life of the community (population is approximately 100,000) and, with Minnesota's lakes country just a half-hour drive away, outdoor activities abound. Competitive salary, excellent fringe benefits package and malpractice paid. Contact: Dr John Hicks, Director, Recruiting Division, 1702 South University Drive, Fargo, ND 58103; ph 701-280-3338 or 701-280-8520. 11-12/90;1-4/91

Minneapolis, BC/BE family practitioner or other specialty with emergency room experience sought for the urgent care department of a large multi-specialty group in desirable Twin Cities location. Our medical clinic is a highly reputable, well-established clinic that has been in existence for over 39 years. Salary and benefits are highly competitive. Regular work week expectation without night call or hospital obligation. Send CV and letter of inquiry to Patrick Moylan, Park Nicollet Medical Center, Minneapolis, MN 55416. 11-12/90;1/90

Family practice physician wanted to join solo practitioner in a very progressive suburb of Green Bay, Wisconsin. Clinic is equipped with lab and x-ray facilities. Located near large recreational area. Send CV or contact M. J. Falk, MD, 2353 Ridge Rd, Green Bay, WI 54304; ph 414-494-9685. p11-12/90;1-4/91

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We are seeking a Board-eligible Ob/Gyn with or without subspecialty interest to join a well-established nine-man expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive oriented formula after the first year. Please contact David Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

Wisconsin. Two young BC internists are seeking a third BC/BE internist for well established, rapidly growing practice located in pleasant central Wisconsin University town of 30,000. Ideal practice opportunity with equal balance of consultative and primary care; well equipped 120-bed hospital, 12-bed ICU. Comprehensive benefit package includes first year salary guarantee, full malpractice insurance and partnership buy-in after one year. Send CV to: Stevens Point Internal Medicine, SC, 3504 E Maria Dr, Stevens Point, WI 54481. p10-12/90;1/91

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Internist BC/BE, to join a progressive 13-physician group practice in July 1990. Rural college town 30 miles from St Paul, Minnesota, with community hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701 or 612-436-8809. 3tfn/90

Family practice opportunities in a a group setting. Located in a family-oriented economically strong small city. Located near lakes and 40 minutes to Green Bay or Appleton. Contact Andrew V. Lagatta, President & CEO, Clintonville Community Hospital, 35 North Anne St, Clintonville, WI 54929; ph 715-823-3121. p8-12/90;1/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: allergy, cardiology, dermatology, family medicine, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, surgery/general, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 9tfn/90

General Internist. Marshfield Clinic, a growing, nationally recognized 350 physician comprehensive multispecialty group, seeks BC/BE general internists to join its 30 member section in Marshfield and regional centers in Central and Northern Wisconsin. Skilled colleagues, democratic governance, modern facilities, state-of-the-art equipment, post graduate training programs, clinical research, diverse practice opportunities, competitive salaries/benefits, an expanding regional health care system, an extremely low physician turnover rate (3.4%), and an unwavering commitment to quality patient care all contribute to a stimulating, satisfying, secure professional environment. The unpolluted tranquil rural location, outdoor recreation, low crime rate, and excellent school system present an ideal family environment. At present, we offer the qualified general internist a variety of locations and practice opportunities. Including: traditional general internal medicine practice; scheduled practice in immediate care or emergency care; focused practice in perioperative medical care, chemical dependency, geriatrics or psychiatric unit medicine. Send CV to: David L. Draves, Dir. of Physician Recruitment, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449. Or, call 1-800-826-2345, ext. 5376. 1-2/91

For Sale

Farm land. 289 acres, 1/2 mile stream, good hunting, 6 years of CRP left. Seventeen miles southwest of Madison, Wis. $800/acre. Gold Crown Farms, Rt #2, Belleville, WI 53508
12/90;1-2/91

Ski-Vail, Beaver Creek, Colorado. Beautiful two bedroom, two bath condo, 1100 sq feet, located at the entrance of Beaver Creek. For more information call Herald Trimmell, DDS; ph 414-567-8386. 12/90;1/91

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THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association*.

Medical Meetings-Continuing Medical Education

February 5-7, 1991: Indianhead Symposium and Ski Outing, Lakewoods, Cable, Wisconsin. Sponsored by Wisconsin Academy of Family Physicians 414-784-3656. Eight hours CME–Mayo Clinic Faculty, Skiing at Telemark, 1-800-255-5937. 10-12/90;1/91

February 7-8, 1991: 15th Annual Winter Pediatric Seminar at Powdermill Inn, Bessemer, Michigan. For further information contact: Marshfield Clinic's Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449 or call 715-387-5207 or 1-800-782-8581, ext 5207.
12/90;1/91

AMA

June 23-27, 1991: Annual AMA House of Delegates, Chicago.
December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1991-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1991 - April 18-20: Milwaukee
Wyndham Hotel
1992 - April 23-25: Milwaukee
1993 - April 15-17: La Crosse
Convention Center, Radisson
1994 - April 14-16: Milwaukee

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday; the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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1991
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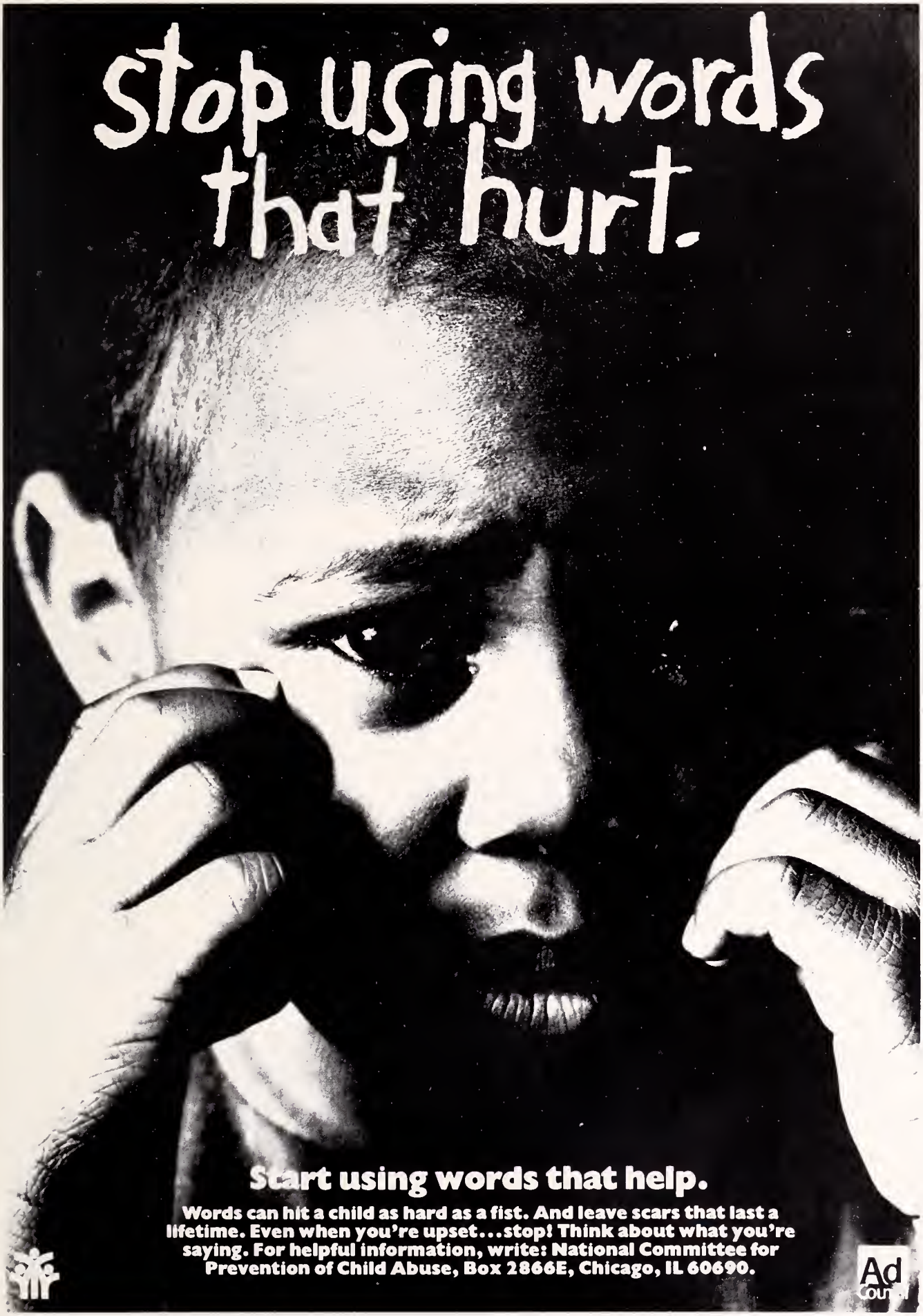

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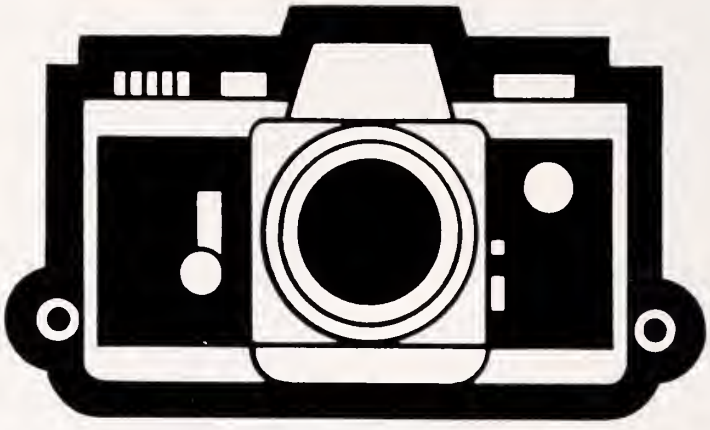

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February 1991 Vol. 90 No. 2

Opinions

51 *Secretary's report*
Of budgets, taxes and red ink
by Thomas L. Adams, CAE, Madison

Letters
52 Physician award
by Vinoo Cameron, MD, Athens
52 Comments on the Persian Gulf war
by Franklin N. Roemhild, MD, Bayfield
54 Drug promotion
by Robert H. Mikkelsen, MD, Fond du Lac
54 Medical assistants
by Julie Harder, CMA, Marshfield

Scientific

55 Group A streptococcal supraglottitis: three case reports
by Jeffrey S. Garland, MD; Thomas B. Rice, MD; Karen J. Wendelberger, MD; and Peter L. Havens, MD, Milwaukee
58 Accuracy of breast frozen section diagnosis in the community hospital setting: a detailed analysis of 628 cases
by James G. Caya, MD, Milwaukee
61 Cardiac tamponade complicating a case of fever of unknown origin
by Michael A. Borkowski, MD; Elliot Weinhouse, MD; and Larrie Sarff, MD, Milwaukee
64 Complications in the use of prochlorperazine
by Thomas J. Luetzow, MD, Larsen

Socioeconomic

67 Klug moves for change
by Marlene A. Scott, assistant editor
70 Healing the healer: a primer on physician impairment
by David G. Benzer, DO, Wauwatosa
80 *Public health*
Project SENSOR: Wisconsin surveillance of occupational carpal tunnel syndrome
by Lawrence P. Hanrahan, MS; Dee Higgins, RN; Henry Anderson, MD; Linda Haskins; and Simon Tai, PhD, Madison
84 HMO financial reports

Organizational

85 Nominees for SMS offices: 1991
89 Physician briefs
90 County society news
90 Obituaries

Our cover: Representative Scott Klug (R-Madison). See page 67 for an introduction to the freshman Congressman.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Secretary's report

Of budgets, taxes and red ink

ESTIMATES OF THE IMPENDING state budget deficit are hovering around $700 million. Think about that. Our state government, unlike the federal government, is prohibited by law from operating with a budget deficit, so the governor and Legislature must raise taxes, slash state funding, or both. Gov. Tommy Thompson assures us that the problem is manageable, but–although I wish him well–he will have to forgive me if I seem less than optimistic.

The choices facing the men and women working under the Capitol dome will be agonizing. Right or wrong, Wisconsin has a reputation as an overtaxed state, and few leaders, and even fewer taxpayers, will warm to the idea of tax increases. At the same time, the programs that are funded by the state are of vital importance to a great many groups of people in Wisconsin. Do you spend to enhance education and cut programs for teenage mothers, or cut funds for law enforcement and spend more on programs for premature babies? The homeless, the environment, AIDS, economic development, drug abuse, urban crime–the list of serious social concerns, each with its own special interest group laying siege at the Capitol, seems almost endless.

One of the programs that is facing a shortfall is Medicaid, although the governor is quick to point out that the Medicaid problem is not caused by the state government, but by the federal government's failure to adequately fund the mandates it hands down. The state Legislature had appropriated funds to increase both obstetric and pediatric reimbursement to 75% of charges, but the governor partially vetoed the increase with a promise to reinstate it as of July 1, 1991, "if funds are sufficient." The "insufficient funds" excuse is now being invoked, although it wears a little thin when proposed funding for hospitals, nursing homes and HMOs all show substantial increases.

At the center of the debates that rage on about the various claims to state funds will be the question of property taxes. Right or wrong, property taxes remain a focal point for political discussions in Wisconsin, which brings me to a point on which I cannot resist commenting. Last year, most of us received rebates on our property taxes, and in the last few weeks, most of us have received notices that we must declare those rebates as income to the IRS. In effect, we have transferred a significant number of dollars from the state treasury to the federal treasury with only a quick detour through the wallets of Wisconsin's taxpayers. That fiasco is an example of how wrong things can go when our elected leaders play political games with tax dollars. We cannot afford any more such ploys. We need responsible decisions about how our tax dollars will and will not be spent.

Thomas L. Adams, CAE

Because of the sharply limited number of dollars available, those decisions will have to be made in the context of a serious ranking of our priorities as a state. And I believe that the health of Wisconsin's residents must take a very high–if not the highest–priority. Your State Medical Society will make certain, during the coming session, that Wisconsin's elected officials understand what is at stake. You can count on it. ❑

Letters

Physician award

TO THE EDITOR: Looking through the pages of the last *Wisconsin Medical Journal*, I could not help but notice the advertisement for the nomination for Physician Citizen of the Year award. A couple of years ago I had a chance to serve on the specific committee that nominates and scrutinizes physicians for such an award. I can not help but reminisce about a comment that a professor of mine from Scotland made: "The greatest awards and medals in medicine are very obscure and personal. If you are looking for medals, you should join the Army." In this day and age we in the profession have to realize that the ultimate salvation of the profession lies in us being true and strong patient advocates. May I suggest that this year's Physician Recognition award be given to those anonymous and obscure physicians who, throughout the state, serve our patients quietly and courageously and compassionately without seeking public limelight.

–Vinoo Cameron, MD
Athens ❑

Comments on the Persian Gulf war

TO THE EDITOR: In [Thomas L. Adams'] *Secretary's report* in the December 1990 issue of the *Wisconsin Medical Journal* ... [he] discussed "the irony that in the civilized global economy in which we exist today one madman could cause such an incalculable potential waste of human lives during this time of year is abhorrent."

My, what an obscene misstatement of facts. There is no civilized global economy. The economy is controlled by a few multinational corporations that are ruthlessly exploiting people ... and the precious resources of this Earth for greedy profit. Power and wealth are being concentrated in fewer and fewer people. Millions of babies, children, and adults starve to death or die of preventable diseases, but we spend more of our money on preparing for war or fighting wars to preserve "our way of life."

[The opinion] said "one madman." How utterly ridiculous.... From what I have read, Hussein had every right to invade Kuwait.... When I say "every right," I mean in how nations conduct their defensive and offensive policies to protect themselves. We have done many similar things in my lifetime (I'm 64)–Vietnam, Grenada, Panama, and many other so-called covert CIA actions–to protect "our interests." Don't forget Nicaragua and how we defied the world court when we mined harbors there. [Don't forget how] our government reassured Hussain a few days before he went into Kuwait that we had no interest in protecting Kuwaiti borders. So who is the real madman? ... [W]ouldn't it be more appropriate to label George Bush as a madman for threatening war there, the consequences of which are horrendously unpredictable and unacceptable?

[The opinion also said] at "this time of year." What is so sacred about now? Not everyone is a Christian. President Bush invaded Panama at this time of the year a year ago, and killed probably thousands of people and destroyed many homes. So-called Christian Christmas celebrants were preparing their homes when they were bombed and burned out and had to flee....

This government does not represent the people any longer. Our government must withdraw our armed forces and work through the United Nations to resolve all the problems of

Continued on page 54

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

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Continued from page 52
the Middle East. War there will not solve anything.... We are in the Middle East for one reason only, to protect the interests of the multinational oil corporations....

Many agree with these concepts. We are far from a truly civilized world. We live in barbaric, cruel, and greedy times. After all, we dropped the bombs on Japan even knowing Japan was ready to surrender, and so on and so on. Our government, with its military industrial base, is really an evil imperialistic empire.

I believe [Adams] owes an apology to the readers of the *Journal.* Calling people mad, and other uses of one-sided opinions, is wrong.

I wish [Adams] well as a human, but I don't agree with [his] approach to a very bad situation.... Sincerely and in peace.

–Franklin N. Roemhild, MD
Bayfield

Editor's note: This letter has been edited to meet space limitations (please see the *Opinion policy* box). ❑

Drug promotion

To THE EDITOR: I have recently received a letter from the Prescription Service Division of the Baxter Health Care Corporation containing a list of prescription medications taken by one of my patients. The purpose of the list was to promote the use of the drug, Misoprostol, to reduce the incidence of gastric ulcers potentially caused by a nonsteroidal anti-inflammatory drug which had been prescribed for the patient.

I was really quite astounded to receive what I would consider confidential information used by a drug company for blatantly commercial purposes. I hope that other physicians who have received similar letters will express their outrage at this promotion.

–Robert H. Mikkelsen, MD
Fond du Lac ❑

Medical assistants

To THE EDITOR: Medical assistants work in physicians offices, outpatient clinics, and ambulatory facilities, performing a wide variety of clinical and administrative duties. We comprise a work force of more than 1 million, and represent the fastest growing career in the United States today.

There is a greater demand for medical assistants today because of the growing number of older Americans needing medical care and the increasing amount of paperwork associated with this care. Medical assistants are professionals who demonstrate their versatility from beginning to end of each patient visit and beyond.

The American Association of Medical Assistants, with its component state societies and local chapters, is the oldest and largest organization for medical assistants. The AAMA is dedicated to the promotion of the professional identity and stature of its members and the medical assisting profession through education and credentialing.

Most of the local chapters meet monthly and direct their meetings toward the education of the members. Programs on the administrative duties, such as insurance, billing, CPT coding and medical legal issues are given, as well as clinical programs on subjects such as drugs, the AIDS crisis, Lyme disease, and health maintenance. Classes are often provided for candidates for the certification examination and for recertification.

The Wisconsin Society of Medical Assistants has more than 350 members. Our society holds professional development seminars to further enhance its members' education. Scholarships are available to students to help with future educational needs.

Encourage your medical assistants to join the AAMA and become certified. Let the Wisconsin society help with their continuing education.

Remember, your medical assistant is your link to your patients, their families, and the ever-present third-party payors. Make sure that link is a strong one.

The Wisconsin Society of Medical Assistants president is Noreen Soeller, CMA, and she may be reached at the following address: 713-A E Doege, Marshfield, WI 54449.

The Wisconsin Society of Medical Assistants is affiliated with the American Association of Medical Assistants.

–Julie Harder, CMA
Marshfield ❑

Group A streptococcal supraglottitis: three case reports

Jeffery S. Garland, MD; Thomas B. Rice, MD; Karen J. Wendelberger, MD; and Peter L. Havens, MD, Milwaukee

We report three cases of supraglottitis caused by *Streptococcus pyogenes*. In contrast to other reports of patients with severe clinical symptoms from supraglottitis with group A beta *Streptococcus*, our patients had mild disease that resolved rapidly and did not require endotracheal intubation. There is a broad spectrum of clinical illness with GABS supraglottitis. *Wis Med J* 1991;90(2):55-57.

Acute supraglottitis is a life threatening illness of the upper airway that most commonly affects children under the age of 7 years. Although *Haemophilus influenza* type B (HIB) is the most common organism responsible for supraglottitis, *Streptococcus* (GABS) and *Staphylococcus aureus* have been reported to cause this disease.[1-4] Lacroix et al[1] reported four cases of acute supraglottitis caused by GABS. All four children required aggressive airway management and a prolonged hospital stay. We report three cases of GABS supraglottitis with less virulent courses to illustrate the variable presentation of this disease.

Dr Garland, Dr Rice, Dr Wendelberger and Dr Havens are with the Critical Care Department, Children's Hospital of Wisconsin and the Department of Pediatrics, Medical College of Wisconsin. Reprint requests to: Peter L. Havens, MD, Children's Hospital of Wisconsin, PO Box 1997, Milwaukee, WI 53201. Copyright 1991 by the State Medical Society of Wisconsin.

Case report one

H.M., a previously well 19-month-old female, developed acute onset of fever, sore throat, drooling and dysphagia six hours prior to hospital admission. In the emergency room, she was in no respiratory distress and able to lie flat. She spoke with a muffled voice. Axillary temperature was 38.5° C, heart rate 128/minute, respiratory rate 24/minute, and blood pressure 108/70 mm Hg. Clear rhinorrhea, a markedly injected throat, and tonsillar hypertrophy without exudates were present. The epiglottis was not visually examined. There was tender anterior cervical adenopathy bilaterally.

The rest of the results of her physical examination was normal.

A lateral neck radiogram showed a swollen epiglottis and aryepiglottic folds. Laboratory analysis at the time of admission included a complete blood count showing: hemoglobin 11.1 g/dl; white blood cell count 17.1 cells/ul including 32% bands and 46% segmented cells; and platelet count 336,000 cells/ul. Cultures of the throat and blood were obtained and cefuroxime (150 mg/kg/day) was started. She was not intubated. Three hours after admission she was afebrile. Within 18 hours of admission, she was taking fluids well. Blood cultures were negative and throat culture grew a pure culture of GABS. A lateral neck radiogram done after 48 hours of antibiotics showed resolution of epiglottic and aryepiglottic fold swelling. After 48 hours of intravenous cefuroxime, the patient was switched to oral penicillin and discharged from the hospital.

Case report two

A. J., a previously well 10-year-old female, developed fever and sore throat one day prior to hospital admission. On the day of admission she developed hoarseness and complained of shortness of breath. She was unable to swallow. At presentation, her axillary temperature was 38.4° C, heart rate 118/minute, respiratory rate 26/minute and blood pressure 112/90 mm Hg. She was in no distress. Her voice was hoarse. The uvula was erythematous and tonsils edematous. Laboratory analysis included: hemoglobin 15 gm/dl; white blood cell count 10,600 cells/ul with 3% bands and 77% segmented cells; and the platelet count was normal. A lateral neck roentgenogram showed and enlarged epiglottis and aryepiglottic folds. The sublottic trachea and retropharyngeal space were normal. Indirect laryngoscopy revealed a swollen and erythematous epiglottis.

The patient was admitted to the intensive care unit where a throat culture and blood culture were taken prior to initiating intravenous nafcillin (150 mg/kg/day), chloramphenicol (100 mg/kg/day) and decadron (0.4 mg/kg/6 hours). Flexible bronchoscopy done for diagnosis and to obtain a culture revealed a markedly swollen beefy red epiglottis and aryepiglottic folds.

Throat and bronchoscopic cultures grew GABS. Blood cultures were negative. The patient was afebrile 12 hours after starting antibiotics. A lateral neck roentgenogram 24 hours after admission revealed resolution of epiglottic and aryepiglottic swelling. After 48 hours of intravenous antibiotics, the patient was switched to oral amoxicillin. She was discharged after three days.

Case report three

J.J., a 15-year-old previously healthy male developed sore throat and temperature to 38.5° C one day prior to hospital admission. The evening prior to admission he was unable to swallow liquids or saliva. In the emergency room, he was unable to talk, was drooling, and had severe dysphagia. He appeared ill, but had no stridor or respiratory distress. His heart rate was 120/minute, respiratory rate 26/minute, blood pressure 112/70 mm Hg and axillary temperature 39.1° C. The soft palate was edematous and covered with petechiae. The tonsils had no exudate. The submental area was very tender without adenopathy. The results of the rest of his physical examination was normal: hemoglobin 14.2 gm/dl, and white blood cell count 12,400 cells/ul, of which 40% were bands and 55% segmented cells. A lateral neck roentgenogram showed a swollen epiglottis. Flexible bronchoscopy revealed a moderately edematous and erythematous epiglottis. A blood culture taken prior to initiating nafcillin (150 mg/kg/day) and chloramphenicol (100 mg/kg/day) was negative. A tracheal aspirate taken at bronchoscopy grew a pure culture of GABS.

Fourteen hours after starting antibiotics, he was afebrile, talking and drinking. Nafcillin and chloramphenicol were continued for 72 hours, at which time he was switched to oral amoxicillin and discharged.

Discussion

Acute supraglottitis is an uncommon but potentially fatal cause of upper airway obstruction in children.[5] In most cases there is an intense cellulitis of the supraglottic structures, which include the supraglottic, aryepiglotic folds and overlying mucosa.[1] *Haemophilus influenzae* type B is the most common organism cultured from the blood, supraglottic structures or trachea in patients with epiglottitis.[6] *Streptococcus pneumoniae, Staphylococcus aureus, Haemophilus parainfluenzae* and Group A, B or C streptococci,[1-4,6] however, have also caused supraglottitis.

Supraglottitis caused by group A *beta hemolytic Streptococcus* is rare. In a review by Bass et al[2] of 97 patients with acute supraglottis (86/97 were children) seven grew GABS from a direct culture of the epiglottis. None had blood cultures positive for GABS. The age, course, management and outcome of these seven cases is not discussed. In the Berenberg and Kevy[5] series of 41 children with supraglottitis, GABS was grown from the nose or throat in four patients and from the epiglottis in one patient. None had a positive blood culture. Lacroix et al[1] reported the clinical presentation and course of four children with severe GABS supraglottic infections. A literature search located another 39 cases of streptococcal supraglottitis among 1892 cases from 40 reports.[1] Of these only eight were GABS. Ages of the eight cases of GABS were not given.

Although the negative blood cultures in our three patients does not satisfy the most strict diagnostic criterion of supraglottitis, we feel, as did Lacroix et al[1] that these cases represent primary GABS infections of the supraglottic structures because of similarity of clinical characteristics among cases, presence of GABS at the site of active inflammation, absence of HIB and direct visual inspection of inflamed supraglottic structures in two cases.

Similarities between our patients with GABS and those of Lacroix et al[1] include their older age and absence of bacteremia. The mean age of patients reported by Lacroix et al was 6.2 years older than patients with HIB supraglottitis.[6] Two of our three patients were older than 10 years. Over 75% of cases of supraglottitis caused by HIB have positive blood cultures.[6] However, only two of the patients reported by Lacroix et al[1] and none of the children we report had positive blood cultures. These results are similar to what Mayosmith et al[7] reported in their series of adult patients with supraglottitis.

There are several important differences between the patients we report and those of Lacroix et al.[1] The most prominent finding in their series was inflammation of the aryepiglottic folds and supraglottis. A second difference was the severity of the patients illness. Children we cared for were less ill and the hospital course was much shorter. Finally, because of the lack of toxicity, rapid response to antibiotics, and stable course of our patients, none required endotracheal intubation. All four of the patients reported by Lacroix et al[1] were intubated for up to 16 days (mean 7.5 days).

The differences in these two series of patients may represent different extremes in the spectrum of presentation of acute GABS disease. Our cases represent a less severe form of GABS supraglottitis than the children reported by Lacroix et al.[1] Just as the inflammation from GABS pharyngitis may vary from patient to patient,[8] inflammation involving other supraglottic structures will also vary.

Initial and subsequent care of any case of proven epiglottis should be handled only by those skilled in managing difficult airways. Direct

laryngoscopy and tracheal intubation under controlled conditions is the standard care at our institution as it is elsewhere.[9] Cultures should be obtained from the epiglottis and blood. Contrary to a previous report, the patients we report illustrate that not all patients with GABS supraglottitis will have a difficult, prolonged hospital course.

References

1. Lacroix J, Ahronheim G, Arcand P, et al. Group A streptococcal supraglottitis. *J Pediatr.* 1986;109:20-24.
2. Bass JW, Steele RW, Wiebe RA. Acute epiglottitis: A surgical emergency. *JAMA.* 1974;229:671-675.
3. Schwartz RH, Kuerr RJ, Hermansen K, et al. Acute epiglottitis caused by Beta hemolytic group C streptococci. *AJDC.* 1982;136:558-559.
4. Lipson A, Kronick JB, Tewfik L, et al. Group B Streptococcal supraglottitis in a 3-month-old infant. *AJDC.* 1986;140:411-412.
5. Berenberg W, Kevy S. Acute epiglottitis in childhood. *N Engl J Med.* 1958;258:870-844.
6. Daum RS, Bates JR, Smith AL. Epiglottitis (supraglottitis). In: Feigin RD, Cherry JD, eds. *Textbook of Pediatric Infectious Diseases.* Philadelphia, PA: W.B. Saunders Co; 1981:138-146.
7. Mayosmith MF, Hirsch PJ, Wodzinski SF, et al. Acute epiglottitis in adults: An eight year experience in the state of Rhode Island. *N Engl J Med.* 1986;314:1133-1139.
8. Wannamaker LW. Group A streptococcal infections. In: Feigin RD, Cherry JD, eds. *Textbook of Pediatric Infectious Diseases.* Philadelphia, PA: W.B. Saunders Co; 1981:986-995.
9. Holbrook PR. Issues in airway management-1988. *Critical Care Clinics.* 1988;789-802. ❑

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Accuracy of breast frozen section diagnosis in the community hospital setting: a detailed analysis of 628 cases

James G. Caya, MD, Milwaukee

The author presents a detailed analysis of 628 breast frozen sections performed at Columbia Hospital over a 35-month period. These 628 frozen sections came from a total of 574 females and 13 males (mean age 55.3 years and range 20.1 to 95.0 years). Frozen section diagnosis was deferred in 18 cases (2.8%) and diagnostic accuracy for presence or absence of malignant neoplasia was 99.2%; one false positive case (pathologist judgement error) and four false negative cases (two sampling errors and two pathologist judgement errors) were detected. Strict diagnostic accuracy for this series was 98.7%. Fifty-three of 223 positive frozen sections (23.8%) were immediately followed by completion mastectomy. The author discusses the philosophy of frozen section technique and concludes that breast frozen section analysis in a busy community hospital setting can meet and even exceed the accuracy level attained at large academic medical centers. *Wis Med J* 1991:90(2):58-61.

THE MEDICAL LITERATURE is replete with reports describing frozen section diagnosis in patients with breast lesions.[1-3,5,7,9] Unfortunately, although a large proportion of breast surgery in this country is performed at the community hospital level, nearly all papers addressing this subject have originated from academic medical centers; indeed, literature review reveals no previously reported, systematic analysis of breast frozen section diagnosis in a series of patients derived from the community hospital setting. Herein described is an in-depth analysis of 628 breast lesion frozen sections performed at our community hospital over a period of 35 months.

Materials and methods

All breast biopsy and resection specimens accessioned by the Department of Laboratory Medicine at Columbia Hospital (a 350-bed community hospital in Milwaukee) from March 16, 1987, to Feb 15, 1990, were reviewed by the author and breast frozen section accuracy was determined by comparing frozen section diagnoses with final diagnoses as given in surgical pathology reports.

During the study period, the same four Anatomic Pathology/Clinical Pathology, American Board of Pathology certified pathologists rendered all frozen section diagnoses at Columbia Hospital. Three of these individuals received their pathology training at university affiliated programs, two of the four pathologists (including the author) held part-time clinical teaching appointments at the local medical school (Department of Pathology, Medical College of Wisconsin), and all four were in full-time private practice. The aggregate post-residency experience for these pathologists at the start of this study was 65 years (range 5 to 31 years). In many instances, more than one pathologist consulted on a given frozen section and this was recorded for statistical evaluation.

All frozen section technical work was performed either by a pathologist assistant or one of the four staff pathologists. After gross visual inspection (including measurement and resection margin marking, if necessary), breast tissue was embedded in a polyethylene glycol-based medium (Tissue-Tek OCT compound R, Miles Incorporated, Elkhart, Ind). This tissue was frozen at minus 20° C, sectioned at approximately 8 micron intervals using a cryostat (Minotome, International Equipment Company, Needham Heights, Mass) and picked up on room temperature glass slides. The microsections were briefly flamed over a Bunsen burner (to facilitate tissue adhesion onto the glass slide) and stained with an abbreviated hematoxylin-eosin technique (staining sequence: 15 seconds formalin; water rinse; 10 seconds in eosin; 10 seconds in 95% ethanol; 10 seconds in absolute ethanol and repeated rinsing in xylene followed by cover slipping).

Upon completion of each frozen section, the frozen section block and remaining, nonfrozen tissues were processed according to standard histologic technique using 10% buffered formalin fixed, paraffin embedded blocks sectioned at 6 micron intervals followed by routine hematoxylin-eosin staining. All histologic preparations on permanent embedded tissues were performed by one of the same three registered histotechnologists employed in our laboratory during the study period.

All cases were reviewed by the author. Any breast frozen sections that were falsely positive or negative for malignant neoplasia were subjected to a review of all histologic materials (including the actual frozen section slide as well as frozen section block microsections and permanent microsections from previously non-frozen tissue). Diagnostic errors were categorized as either sampling error (lesion included with the specimen sent to surgical pathology at the time of frozen section, but not included in the sample submitted

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for actual freezing) and pathologist judgement error (in which case diagnostic tissue was indeed present on the actual frozen section slide itself).

Results

Five hundred and eighty-seven patients (574 females and 13 males) had an aggregate total of 628 breast frozen sections over the course of this study. The age mean was 55.3 years, with a range of 20.1 to 95.0 years. During the 35 months of this study, our laboratory accessioned a total of 1,876 breast tissue specimens and 605 of these accessions (32.2%) had one or more frozen sections (23 patients each had two frozen sections on the same accession). The mean number of pathologists evaluating each frozen section was 1.65. Fifty-three of the 223 positive frozen sections in this series (23.8%) were immediately followed by completion mastectomy.

Table 1 enumerates the diagnoses rendered in our 628 cases; 18 of our 628 frozen section diagnoses (2.8%) were deferred pending availability of permanent microsections. Table 2 represents a detailed analysis of five cases in which the frozen section and final pathologic diagnoses were discrepant (ie, one false positive and four false negative cases). In addition to those cases falsely positive and falsely negative for malignant neoplasia, three examples of less significant discrepancy were recorded: one case diagnosed as fibrosis on frozen section but as fibrocystic disease proliferative type, with focally severe atypia on permanent microsections (sampling error); a case of duct ectasia on frozen section diagnosis but fibrocystic disease with atypia on permanent microsections (sampling error); and, a case diagnosed as fibroadenoma on frozen section but as fibrocystic disease on permanent microsections (judgement error).

Our diagnostic accuracy for assessing the presence or absence of malignant neoplasia was 99.2%. A somewhat more strict definition of diagnostic accuracy (complete concordance between frozen section and final diagnoses) would separate out the three frozen section cases of benign disease in which there was still some discrepancy between the frozen section and permanent microsection diagnoses (see above). If one categorizes these as inaccurate diagnoses, the strict diagnostic accuracy for this series is 98.7%.

Discussion

The use of frozen section diagnosis for intraoperative consultation dates to the 19th century but did not attain general acceptance in the medical community until the 1950s.[3,4] Since then, numerous analyses of the technique have been published but nearly all of these have originated from academic medical centers. In fact, the author is aware of only one study examining frozen section accuracy in the non-academic hospital setting, but this analysis did not systematically segregate breast from extra-mammary specimens.[2]

This study of 628 breast frozen sections was noteworthy from several perspectives. First, all frozen sections were reviewed by one or more of the same group of four pathologists and were processed by the same pathologist assistant as well as the same group of three histotechnologists; this constancy of specimen handling and interpretation was enhanced by the fact that nearly all breast biopsies and resections were submitted from one of ten breast surgeons active at Columbia Hospital during the study interval.

Second, literature review revealed only one previous study documenting the frozen section experience in a community hospital setting but this report did not entail a systematic, detailed analysis of breast cases.[2]

Finally, this study demonstrated that breast frozen section analysis, as performed at the community hospital level, can meet and even exceed the accuracy reported from multiple comparable series derived from the academic sector.

Table 1.–Distribution of frozen section diagnoses (n=628).

Frozen section diagnoses	Number	Comment
malignant neoplasm	223	Includes 1 malignant lymphoma and 1 false positive (malignant neoplasm, not otherwise specified); remainder of cases primary breast carcinoma.
fibrocystic disease	193	
fibroadenoma	105	Includes 3 lactating adenomata
fibrosis/duct ectasia/ no residual tumor	42	
diagnosis deferred	18	
mastitis/fat necrosis/	16	Includes: 2 abscesses; 2 cases of fat necrosis; 1 granulomatous mastitis; 1 plasma cell mastitis
papilloma	11	
gynecomastia	10	
benign lymph node	6	Intramammary lymph node tissue
lipoma	2	
hemangioma	2	

When assessing for the overall accuracy of breast frozen section with respect to the presence or absence of malignant neoplasia, this study compared quite favorably with those in the literature that originated from full-time academic centers; indeed, breast frozen section deferred diagnosis rates reported in the literature ranged from 0.4-20.5%[1,5,7,8] and reported diagnostic accuracy was in the 97.9-99.9%[1,2,5,7,8] range. One study of 3451 patients had an overall diagnostic accuracy 99.9% but this series was also particularly noteworthy for a 20.5% deferred diagnosis rate.[1]

Pathologists and their laboratory colleagues labor in an era characterized by ever-escalating demands and expectations on the part of clinicians and patients alike. Although the frozen section technique is a proven tool in the medical armamentarium, it is not without limitations. We in the laboratory must work to educate clinicians and patients that frozen section analysis is not infallible nor is it appropriate for all clinical circumstances. Freezing any tissue introduces artifactual distortion that can hinder interpretation of the actual frozen section slide as well as permanent microsections later made from the frozen section block. Furthermore, in cases where only a small amount of tissue is available, performance of a frozen section may result in a situation whereupon little or no tissue remains for permanent microsections and diagnostic accuracy may be compromised.

The definitive therapy for breast carcinoma has evolved considerably over the past 20 years. Whereas most positive breast frozen section diagnoses were once immediately followed by completion mastectomy, patients now frequently elect to defer therapy until the final pathology result is available and they have had an opportunity to discuss and evaluate therapeutic options that include less radical surgical procedures as well as adjunctive modalities including radiation therapy, hormonal manipulation and chemotherapy. This shift in decision-making philosophy and therapeutic options has relieved the pathologist of considerable stress when dealing with the difficult borderline breast frozen section case.

For example, in this series, only 23.8% of positive breast frozen section diagnoses were immediately followed by completion mastectomy. Fortunately, the only false positive case in this series was that of a patient whose physician did not pursue immediate completion mastectomy, thereby allowing for examination of permanent microsections and the appropriate final diagnosis of a benign mesenchymal lesion.

In the author's experience, most breast frozen sections are currently being done to satisfy patient and clinician curiosity, as well as to allow for expeditious performance of hormonal receptor analysis (estrogen and progesterone) should a diagnosis of cancer be returned by the pathologist. A minority of breast frozen sections (approximately one-quarter) have any immediate intraoperative effect on the scope of the surgical procedure itself.

The pathologists at Columbia Hospital uncommonly refuse to perform a frozen section. The major exception to this is in cases whereby mammographically detected microcalcifications are unaccompanied by any discrete mass. In this situation, the pathologist explains to the surgeon that frozen section may well preclude meaningful assessment and histologic evaluation is therefore deferred until permanent microsections can be made.

Breast biopsy hormonal receptor analysis at Columbia Hospital is currently being done by an outside reference laboratory using an enzyme linked immunoassay performed on a standard cytosol preparation. Our laboratory is investigating the possibility of performing semi-quantitative receptor analysis using the immunoperoxidase technique on formalin fixed, paraffin embedded tissue. Should this prove successful, the putative need for breast frozen sections at our hospital could be substantially reduced.

Our current practice environment

Table 2–Cases discrepant between frozen section and final pathologic diagnoses.

Frozen section diagnosis	Final diagnosis	Type of error*
malignant neoplasm, not otherwise specified	Pleomorphic lipoma	PJE;FP
intraductal papilloma	Intraductal carcinoma, multifocal	SE; FN
no evidence for carcinoma	Intraductal and infiltrating duct carcinoma	SE; FN
fibrocystic disease with papilloma	Intraductal carcinoma multifocal	SE; FN
fibrocystic disease with papilloma	Intraductal carcinoma multifocal	SE; FN

*PJE = pathologist judgement error
SE = sampling error
FP = false positive for malignant neoplasia
FN = false negative for malignant neoplasia

is dominated by concern over medicolegal and cost containment issues coupled with a stated desire to enhance quality of care. By educating our clinicians and patients about the costs, indications and limitations of breast frozen section analysis, we can better address the needs of health care consumers. Furthermore, by performing detailed analyses of our frozen section accuracy, we can enhance the quality of care to the patients we serve by identifying diagnostic problem areas (as well as patterns of inappropriate frozen section requests) and the means to successfully address them.

Conclusion

This study provides sound evidence that the accuracy of breast frozen section diagnosis in the community hospital setting can meet and even exceed that achieved at academic medical centers. Critical to the attainment of high diagnostic accuracy in any health care institutional setting is the experience level of clinicians and pathologists alike. Well trained, interested and enthusiastic pathologists who see a large volume of diagnostic breast material, would be expected to develop a high level of diagnostic acumen. Since a large proportion of breast surgery performed in this country transpires in the community hospital setting, it is not surprising that pathologists in such a setting would attain special expertise in this area.

Acknowledgment

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References

1. Agnantis NJ, Apostolikas N, Christodoulou I, et al. The reliability of frozen-section diagnosis in various breast lesions: A study based on 3451 biopsies. *Recent Results in Cancer Research.* 1984; 90:205-210.
2. Barnett RN, Richman LW. Accuracy of rapid frozen section diagnosis in a community hospital: A review of 10 years experience at the Norwalk Hospital. *Conn Med.* 1983;47:463-465.
3. Bauermeister DE. The role and limitations of frozen section and needle aspiration biopsy in breast cancer diagnosis. *Cancer* 1980;46:947-949.
4. Fechner RE. Frozen section (intraoperative consultation). *Hum Pathol.* 1988;19:999-1000.
5. Kaufman Z, Lew S, Griffel B, et al. Frozen section diagnosis in surgical pathology: A prospective analysis of 526 frozen sections. *Cancer.* 1986; 57:377-379.
6. Kindschi GW. Frozen sections: Their use and abuse. *JAMA.* 1984; 251:2559-2560.
7. Rogers C, Klatt EC, Chandrasoma P. Accuracy of frozen section diagnosis in a teaching hospital. *Arch Pathol Lab Med.* 1987;111:514 -517.
8. Sawady J, Berner JJ, Siegler EE. Accuracy of and reasons for frozen sections: A correlative, retrospective study. *Hum Pathol.* 1988;111:514-517.
9. Schwan HD. Frozen section diagnosis of breast tissue: Indications and limitations. *Diag Gynecol Obstet.* 1981;3:347-352.❑

Cardiac tamponade complicating a case of fever of unknown origin

Michael A. Borkowski, MD; Elliott Weinhouse, MD; and Larrie Sarff, MD, Milwaukee

A 16-year-old male was transferred to Children's Hospital of Wisconsin (CHW) after 17 days of fever of unknown origin. An echocardiogram revealed a small pericardial effusion only. Serial echocardiography demonstrated an increased size of this effusion with collapse of the right atrium during diastole. A subxiphoid open pericardiostomy was performed to relieve the impending tamponade and to assist in the diagnosis of his fever. The diagnostic criteria for cardiac tamponade are discussed. *Wis Med J* 1991;90(2):61-63.

THE PATIENT WAS a 16-year-old boy hospitalized for 46 days because of fever of unknown origin (FUO). Despite an exhaustive workup, the etiology was never determined. He was previously healthy with a 1-week history of pharyngitis and fever which did not respond to amoxicillin therapy. He was admitted to an outlying hospital because of progressive weakness and was treated with Claforan.

Claforan was discontinued on day five when a macular papular eruption developed.

He developed a right pleural effusion and a thoracentesis performed on day 14 revealed 60 cc of purulent fluid with 37,000 WBCs of which 92% were PMNs. Bacterial cultures, cytology and acid fast stains from this fluid were negative. An echocardiogram showed a very small pericardial effusion only. His fever spikes continued and he was started on Primaxin. He was transferred to CHW two days later.

On examination, he appeared toxic. His temperature was 38.6° C, heart rate 104/min, RR 28/min and BP 103/76 mm Hg with no pulsus paradoxus. His JVP and peripheral pulses were normal. His HEENT examination was normal. He had clear breath sounds and a normal aeration pattern. He had a slightly hyperactive precordium with a PMI barely detectable at the 5th left intercostal space just to the left of the mid-clavicular line. There was no cardiomegaly to percussion or to palpation. His heart tones were muffled. There were no gallops or rubs. He had a grade I-II/IV systolic ejection type murmur along the left sternal border. His abdomen was diffusely tender but otherwise normal. His extremities were normal. Neurological evaluation was normal. His skin revealed no lesions.

The EKG reading was normal. Chest films showed an enlarged heart shadow and bilateral blunting of the costal-phrenic angles. No pulmonary edema was observed. An echocardiogram revealed a small to moderate posterior pericardial effusion without any evidence of tamponade.

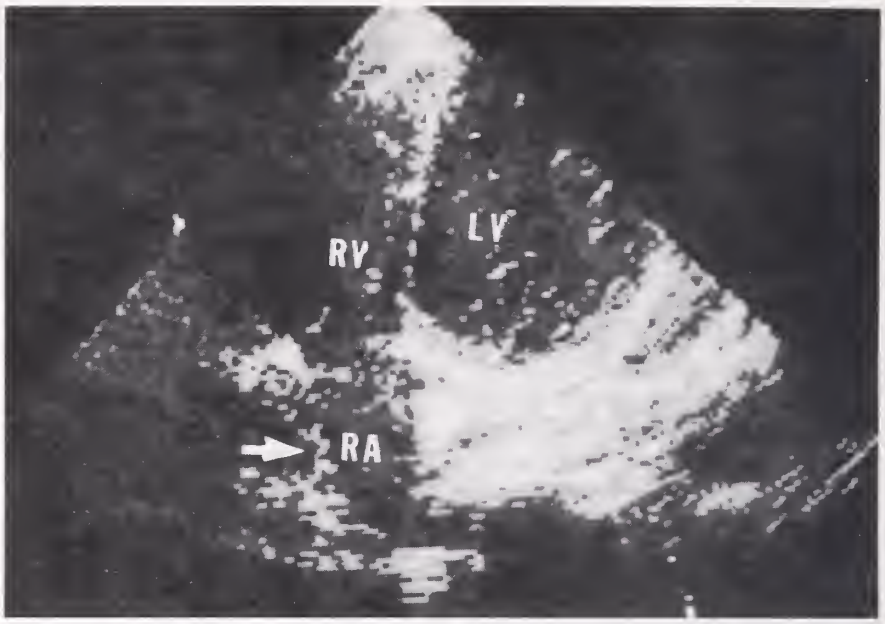

Fig.–Apical four-chamber echocardiogram demonstrating collapse of the right atrium (arrow) during diastole: LV, left ventricle, RV, right ventricle, RA, right atrium.

On day five at CHW, he developed increasing respiratory distress. His vital signs were temperature 39.8° C, HR 120/min, RR 46/min, BP 94/65 mm Hg on inspiration and 100/65 mm Hg on expiration. His heart sounds were distant and his PMI was faint. A repeat echocardiogram revealed a large posterior pericardial effusion. The right atrium no longer maintained its integrity in diastole (Fig). The patient appeared to be in impending tamponade.

A pericardial window was established in the operating room and 275 cc of serosanguinous fluid was drained which did not prove to be diagnostic. Two days after the pericardial tube was inserted, the patient was started on prednisone. Follow-up echocardiograms revealed no reaccumulation of his pericardial effusion.

The patient's initial Brucella titers suggested a recent infection with this agent and he had had a history of exposure to raw meat. He was started on Doxycycline and Rifampin. Repeat blood cultures and titers for Brucella, however, were negative, and these antibiotics were discontinued.

He was discharged on Tolectin and his steroids were tapered. He has continued to improve and is free of any significant symptoms 10 months after being discharged. The etiology of his FUO remains unknown.

Discussion

Our patient, had pharyngitis, fever, and progressive weakness suggestive of an infectious etiology, but despite an arduous investigation and a lengthy hospitalization, no specific etiology could be found. He developed a large pericardial effusion and impending tamponade, requiring surgical intervention.

Pericardial effusions can be serous, fibrinous, purulent, hemorrhagic or in combination.[1-5] Our patient's pericardial biopsy and fluid were at best consistent with an idiopathic, viral, or post-viral pericarditis of unknown origin.

Our ability to diagnosis tamponade or pre-tamponade has improved greatly with the advent of echocardiography. In addition to being innocuous to the patient, echocardiography is the most convenient, simplest and most accurate method of detecting pericardial effusions[1,3] and of predict-

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Symptoms and signs associated with cardia tamponade.

Symptoms
dyspnea/orthopnea
fatigue
restlessness
precordial chest pain
Physical findings
tachycardia
jugular venous distension
friction rub
pulsus paradoxus
distant heart tones
edema
hepatomegaly
Diagnostic tests
chest x-ray-enlarged cardiac silhouette
electrocardiogram-electrical alternans
echocardiogram-Prominent respiratory alterations of right ventricular dimension; right atrial/right ventricular collapse in diastole

ing cardiac tamponade.[6,9] The Table summarizes the symptoms, signs and findings on chest roentgenogram, ECG and echocardiogram of tamponade. Because right atrial filling is impaired, central venous pressure rises and is manifested by an elevated level of pulsation of the internal jugular veins.[5] Pulsus paradoxus, defined as a systolic pressure fall during inspiration of 10 mm Hg or more, is often seen in cardiac tamponade. While considered a cardinal sign of tamponade, pulsus paradoxus can also occur in obstructive lung disease (severe asthma), obesity, pulmonary embolism, mitral stenosis, tense ascites, or shock.[4]

The history, physical examination, chest roentgenogram, and electrocardiogram may not prove conclusive for cardiac tamponade. Although definitive, cardiac catheterization is invasive, increases the risk to the patient and requires special monitoring. Our patient did not have pulsus paradoxus or jugular venous distension. He was, however, tachycardic, orthopneic, dyspneic, and fatigued. While these findings are associated with cardiac tamponade, they are not specific. Serial echocardiography demonstrated an increaseing size of the pericardial effusion associated with right atrial collapse during diastole on his last study. Collapse of the right atrium during diastole on echocardiography is an accurate predictor of current or impending tamponade. Of 44 patients reported with pericardial effusions, 41 had clinical or hemodynamic evidence of cardiac tamponade. They were studied for right atrial collapse in diastole as a marker for tamponade.[6-8] The sensitivity of this finding ranged from 64 to 100%, the specificity from 82-100%, and the predictive value or accuracy from 50 to 100%.

Our objectives in caring for this adolescent with a FUO was first to ensure his hemodynamic stability and second to determine the etiology of his disease. We avoided the use of steroidal and non-steroidal anti-inflammatory agents initially so that the pathological process would not be obscured and his diagnosis might be elucidated. In light of the echocardiographic findings consistent with early cardiac tamponade, his effusion was drained with an open procedure and prednisone therapy was initiated. While the etiology of his FUO remains undetermined, he has been free of a pericardial effusion for 10 months.

In conclusion, there are several useful signs and symptoms associated with cardiac tamponade (Table). Echocardiographic demonstration of right atrial collapse during diastole is an important predictor of this life threatening event.[6-8]

References

1. Hancock EW. Pericardial disease: Differential diagnosis and management. *Hosp Prac.* 1983;101-112.
2. Gold RG. Post-viral pericarditis. *Euro Heart J.* 1988;9(Supplement G):175-179.
3. Spodick DH. The normal and diseased pericardium: Current concepts of pericardial physiology, diagnosis and treatment. *J Am Coll Cardiol.* 1983; 1:240-251.
4. Spodick DH. Pericarditis, pericardial effusion, cardiac tamponade, and constriction. *Critical Care Clinics.* 1989; 5:455-476.
5. Hancock EW. Cardiac tamponade. *Med Clin of N Amer.* 1979;63:223-237.
6. Gillam LD, Guyer DE, Gibson TC, et al. Hydrodynamic compression of the right atrium: A new echocardiographic sign of cardiac tamponade. *Circulation.* 1983;68:294-301.
7. Singh S, Wann LS, Schuchard GH, et al. Right ventricular and right atrial collapse in patients with cardiac tamponade: A combined echocardiographic an hemodynamic study. *Circulation.* 1984;70:966-971.
8. Kronzon I, Cohen ML, Winer HE. Diastolic atrial compression: A sensitive echocardiographic sign of cardiac tamponade. *J Am Coll Cardiol* 1983;2:770-775.
9. D'Cruz IA, Cohen HC, Prabhu R, et al. Diagnosis of cardiac tamponade by echocardiography. *Circulation.* 1975; 52:460-465. ❑

Complications in the use of prochlorperazine

Thomas J. Luetzow, MD, Larsen

This case presentation is of a patient who had the clinical appearance of epiglottitis, but actually had an oro-pharyngeal dystonic reaction to prochlorperazine. The intent of the discussion is to alert physicians that the appearance of epiglottitis can occur from causes other than infection and that a surgical airway should not be the first thought when such a case arises. *Wis Med J* 1991;90(2):64-65.

The patient was a 24-year-old woman with no reported chronic health problems. She related only infrequent over the counter drug use. The history of present illness (HPI) began with symptoms of gastroenteritis for two days. One day prior to coming to the emergency department, she began taking a friend's prescription of prochlorperazine 10 mg tablets, ingesting 3 that day. The day of admission she took 1 tablet at approximately 7:30 am and another at noon. She arrived at the emergency department at 3:15 pm with complaints of upper respiratory distress. Her vital signs were: pressure of 132/70, respirations of 20, and pulse of 84. She had no hives and was not wheezing. She did, however, exhibit mild upper airway problems and a dystonic reaction evidenced by slight neck stiffness and difficulty opening her mouth.

When the patient came to the emergency department, the physician on duty was involved with a motor vehicle accident trauma case. Based on the nurse's assessment, an intramuscular (IM) injection of diphenhydramine 50 mg was ordered. The patient's clinical status deteriorated. The woman was awake and cooperative, but had dyspnea and mild dysphonia. Her lung sounds were essentially clear. She had a slight protrusion of the tongue, but she was conversive and able to provide a thorough history, which was negative for any similar reaction or prior prochlorperazine treatment. The intraoral examination findings were normal. No attempt was made at the time to look at the epiglottis or posterior pharynx. Neck abnormalities were not palpable.

The patient was then given a subcutaneous injection of 0.3 cc epinephrine and sent for a lateral soft tissue neck roentgenogram. This revealed a somewhat ill-defined epiglottis of questionable size. Upon return to the emergency department, the patient was acutely distressed, with protrusion of the tongue, drooling, and stridor. She sat leaning forward with a prominent dysarthria. She still had no cyanosis or wheezing. Clinically, she appeared to have epiglottitis.

D5W was initiated intravenously (IM). A bolus of diphenhydramine 25 mg was administered IM. The patient's symptoms improved within one minute. An additional IM injection of diphenhydramine was given five minutes after the IV bolus. The result was complete resolution of airway compromise with only minimal dysphonia remaining. Intraoral examination results remained normal, including visual examination of the posterior pharynx. The lung sounds remained clear; the neck was supple and without localizing nodes. Blood gases after the treatment showed a pH of 7.39, pCO2 of 36 and pO2 of 273 on 6 liters of oxygen. The WBC was 12,000 with a normal differential while the hematocrit was 42.5.

The diagnosis, therefore, was an acute reaction suggesting epiglottotiis secondary to prochlorperazine ingestion. The patient was admitted to the hospital for observation. She was discharged in good condition after an uneventful 24 hours. The radiologist fuond nothing abnormal in the reading of the lateral neck radiogram.

Analysis and conclusion

Complications due to phenothiazines and related compounds have previously been well documented. Most physicians are aware of the relatively common adverse reactions and recognize them as such. This case discusses a very unusual adverse reaction that was not documented in the literature I reviewed through MedSearch. Personal communication with two other physicians revealed two similar cases of pseudoepiglottitis, both responding to diphenhydramine.

Despite volumes of information about adverse effects from phenothiazines and related compounds, only limited information was found related specifically to prochlorperazine-induced adverse reactions. Bateman, Rawlins and Simpson[1] reported that during a 15-year period, 104 cases of suspected extrapyramidal reactions associated with prochlorperazine were reported from annual prescription rates of 1.4 to 2.9 million (1967-1982). Reporting rates were estimated between 1-10%. Ninety-nine (99) of these reports were dystonia-dyskinesia, usually developing within three days of treatment onset. The majority of the patients had received standard doses, thus the adverse reactions were not attributable to an overdose.

Baker and Cook[2] discussed prochlorperazine complications in two patients, but neither had problems with the airway.

A literature review published in 1969 by LaPierre, Amin, and Hattan-

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gad[3] investigated prochlorperazine adverse effects since 1956. Several rare findings included: four cases of blood dyscrasias; occasional jaundice with one case of cholestasis and jaundice; one case of reversible circulatory failure in a patient with a pheochromocytoma; one case of hypotension in a previously hypertensive patient; and one asphyxial death. No mention was made in the latter case of airway compromise.

The *JAMA* "Letters to the Editor"[4] documented akathisia in one patient while dyskinesic movements were reported in a patient in *Clinical Neuropharmacology.*

A review of extrapyramidal reactions secondary to phenothiazines was reported by Ayd.[5] Adverse reactions were documented in 150 of 350 patients receiving prochlorperazine. Some of these patients exhibited dysarthria but no disruptions suggestive of epiglottis were noted.

Leeman[6] noted three patients with thick-tongue sensation and dysarthria as a result of small doses of prochlorperazine.

The Australian literature recently cited two cases of airway compromise somewhat similar to this case report. Newton-John[7] described symptoms of "choking, difficulty breathing and coughing with lingular dystonia." Prompt control was obtained with intraveneous benztropine mesylate. Though an epiglottitis-like adverse reaction is a very rare side effect of prochlorperazine, and possibly other phenothiazines, physicians need to be aware of this potential problem since rapid therapy with parenteral diphendydramine (Benadryl) or benztropin mesylate (Cogentin) is curative. Early recognition and treatment can prevent surgical airway intervention.

References

1. Bateman DN, Rawlins MD, Simpson JM. Extra pyramidal reactions to prochlorperazine and haloperidol in the United Kingdom. *J of Med.* 1986;230:549-556.
2. Baker FM, Cook P. Compazine complications: A review. *J Natl Med Assoc.* 1981;5:409-412.
3. LaPierre J, Amin M, Hattangad S. Prochlorperazine - Review of the literature since 1956. *J Can Psych Assoc.* 1969;14: 267-274.
4. Letter to the editor. In: *Clin Neuropharm.* 1984;7:171-172.
5. Ayd F. A survey of drug-induced extrapyramidal reactions. *JAMA.* 1961;175.
6. Leeman C. Acute dystonic reactions to small doses of prochlorperazine. *JAMA.* 1965;193.
7. Newton-John H. Acute Upper Airway Obstruction due to Supraglottic Dystonia Induced by a neuroleptic. *Br Med J.* 1988;297(6654):964-965.

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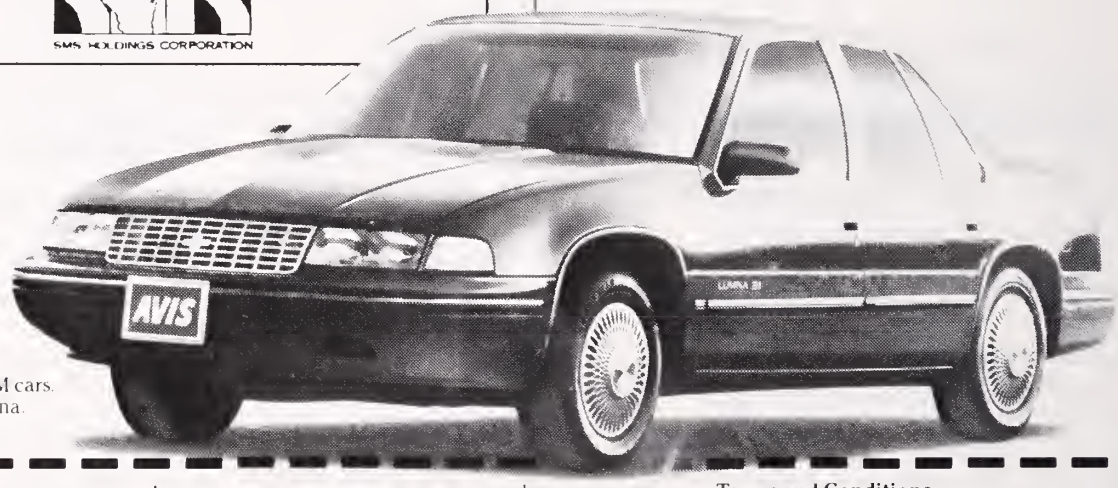

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Klug moves for change

Marlene A. Scott, assistant editor

Scott Klug began his term as Wisconsin's representative from the 2nd district at a difficult time. The United States is involved in the Persian Gulf war and the budget is an incomprehensible $3.4 trillion in debt. Does the former television anchor mind the challenge? Apparently not.

"Because of my background as a investigative journalist," said Klug, "I have a natural tendency to want to dig up the truth and hammer away at the institution."

Klug, a native of Milwaukee, says he considered running against Democrat Robert Kastenmeier about the time he was completing his MBA at the University of Wisconsin and also co-anchoring the news at WKOW Channel 27 in Madison. While enjoying a pizza with friends, one of them suggested he run against the Democrat who held the office for more than 32 years.

"That (suggestion) planted the seed," said Klug. "Then I spent 4 or 5 months talking to Ann Haney and Jim Johnson, who had challenged Kastenmeier previously, and a number of other people involved in party politics, did a lot of soul searching, and finally decided I really wanted to do it."

Klug will be no stranger to Washington. He worked there as an investigative reporter in 1981. A history major at Lawrence University, Klug graduated with a Masters Degree from Northwestern University's Medill School of Journalism in 1976. His television career began after graduation with a job at a Wausau television station.

After a year and a half in Wausau, Klug moved to Seattle and joined KING-TV in Seattle. It was there that he earned his reputation as an investigative reporter, uncovering racketeering scandals involving county sheriffs and winning regional broadcasting awards for his work.

In 1981, Klug took a job at Washington, DC television station, WJLA. He continued to rack up his accomplishments, including 11 Emmys from the Washington, DC Chapter of the National Academy of Arts and Sciences.

After 7 years at WJLA, Klug decided to make a move. He and his wife, Tess, chose to relocate to Wisconsin for personal reasons and he landed the WKOW co-anchor job. He was there for 2 years before making his political move.

"The longer I was away from Washington and the more I read, the more angry and frustrated I became," said Klug. "I think everybody has a time in their life when they want to do public service, and this, for me, was the time when I wanted to do public service."

Klug feels his previous role as a journalist will mesh well with his new duties as an elected official. As a matter of fact, he thinks it's as good a training as any other discipline.

Candidate Scott Klug (l) receives an AMPAC contribution check from SMS Secretary-General Manager Thomas L. Adams during the campaign. Klug won the 2nd district Congressional seat.

"I think journalists, in a lot of ways, make great elected officials for a number of reasons," said Klug. "First of all, their first inclination is to listen rather than talk, which I think distinguishes them from many politicians. I'm much happier sitting in a coffee shop in Sun Prairie listening to somebody tell me what they think is wrong rather than me sitting up on some stool pontificating."

"Reporters also have a pretty good nose," said Klug. "You know when something's not right or how the

Continued on next page

Scott Klug (c) is sworn in by Speaker of the House Thomas Foley (l), with support from his family: Brett (in Klug's arms), Keefe and Tess (r).

public feels. You're in tune with those rhythms and attitudes."

"I think there's always a little bit of a crusader or reformer in most journalists," said Klug. "I think that fits pretty well, and I'm going to Washington because I really want to try to make a difference."

Klug says that, although he is considered a freshman legislator, he doesn't see his role any differently than if he were a veteran on Capitol Hill. Klug believes that anybody in Congress really has three roles.

"You are an agitator for your ideals and values, you must do constituent services and you must do legislative work," said Klug. "Clearly, for any freshman, if you're in any way realistic, the legislative role won't fully blossom the first 2 years in office."

Klug says that being a Republican freshman puts him at the "bottom of the totem pole" in a rather substantial minority. He feels that his ability to make a difference will matter more in his ability to argue for his constituency and to argue for some positions or ideas he holds true. Forming legislation, says Klug, will come slowly. But he says he's prepared to listen and learn. Klug also feels that if the "freshman class," 18 Republicans, holds together, more work will be accomplished.

"If we (the freshman) hang together and really have a sense of vision and goals of what we want to accomplish in Congress, then I think we will have much more of an impact on what happens as freshman," said Klug.

Will Klug put medicine at the forefront of the numerous issues he hopes to tackle?

"We are faced with an increasing problem of the underinsured and the uninsured in this country," said Klug. "I think this is a problem that will gather more steam as more and more middle class people are affected."

Klug says the Pepper Commission's long-awaited study will show that there is increasing pressure to provide insurance coverage to those people who are left without.

"I believe that it calls for a universal approach," said Klug. "But I don't know if it's a political problem as much as it is a social problem."

"We expect doctors to provide the best care no matter what the age of the patient is, and with all the latest hi-tech equipment," said Klug. "And if it doesn't work out, we'll sue."

Klug says the Canadian and the British systems are much different, but have their own inherent enigmas. "The problem is that everyone who agitates and argues for those other systems, I don't think realize what a real sense of rationing there is that lies at the fundamental heart of those systems."

"Before we can even think about going to a new system, we have to really change the attitudes in this country," said Klug. "I think a lot of the problems we have in health care now reflect cultural problems, and until we are ready to address some of those, I don't know how we are going to change it." Klug said that the laws themselves won't change anything.

Klug also said that the issue of the uninsured and underinsured should be addressed on a state level. "As often as we can keep the decisions closer to the people, I think they have a better chance of controlling and responding to them. Whenever possible I'd rather see much more policymaking done at the state level as well as many more budget decisions. I think the state government is in a better situation to handle it than Congress is."

Klug said that his stance on the additional proposed cuts of the Medicare budget will not be particularly "politically popular." Currently, President Bush wants to cut another $14.3 billion dollars from the already reduced by $39 billion Medicare budget. "If we are going to make some kind of serious dent in the budget, then it seems to me that we have to begin to apply some kind of means testing if we are going to make or get control."

"When we give aid to any group in this country, whether it's kids or young families or men and women, we always use some income standard or level to determine whether people are eligible for those benefits, except when they get to become 65 years old," said Klug. "It doesn't seem to me to make a great deal of sense that Ronald Reagan or Lee Iaccoca, when they retire, are going to have the same kind of options for Medicare and Medicaid coverage as does

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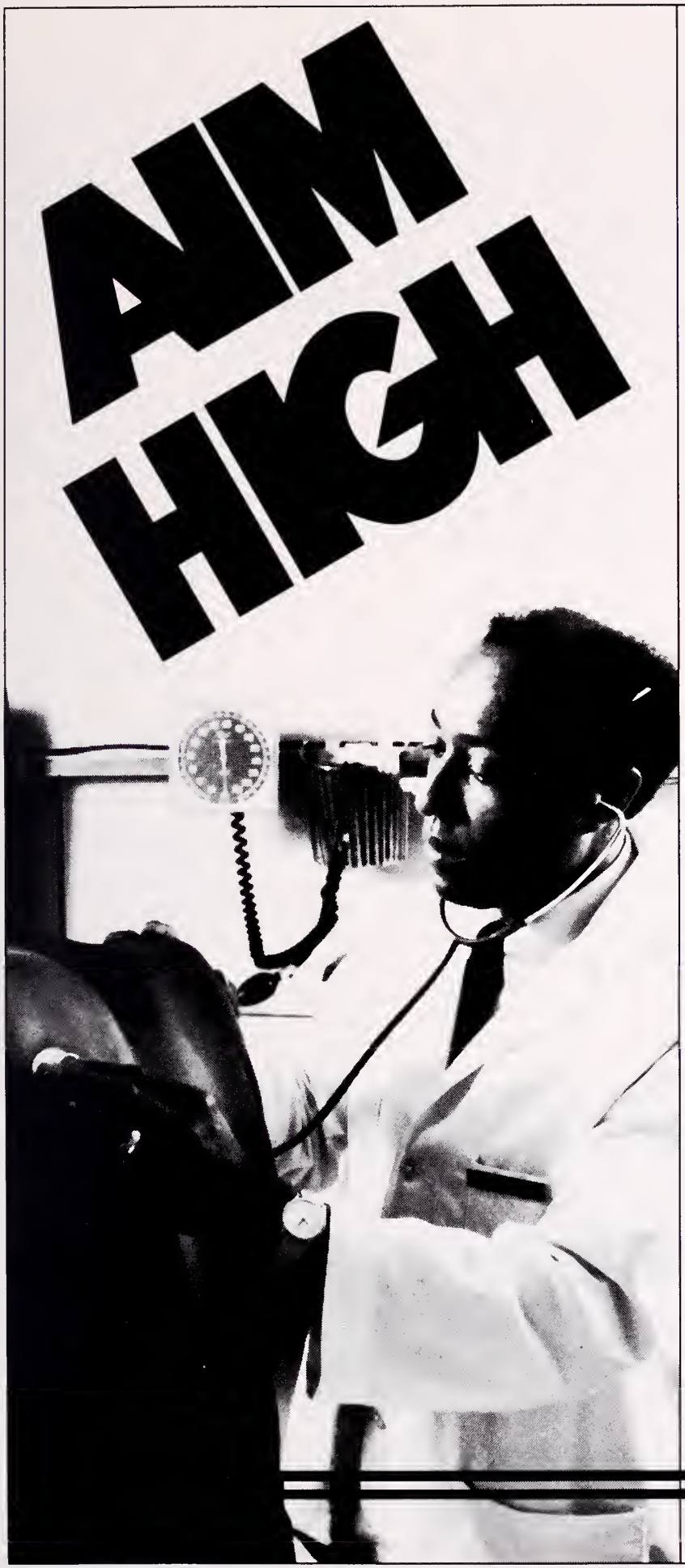

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Continued from page 68
somebody whose living on $800 a month Social Security and clearly can't afford it."

Klug feels that foreign policy, the health insurance issue and the budget will top the concerns of the 102nd Congress. And his own personal pledge is to limit Congressional terms to 12 years.

"The health care issue is becoming hotter and hotter," said Klug. "In the next 10 years we are going to have to address this issue. Up to this point, I haven't seen the perfect plan. Maybe there's not one. Maybe that's the issue."

Klug said he's grateful for the help of the American Medical Political Action Committee (AMPAC) and a number of individual physicians who helped to make his campaign a success. "Bob (Kastenmeier) was a very vocal proponent of socialized medicine and all the traditional ramifications of that," said Klug. "And, I think, physicians - just as a number of other members of the public - were really ready for a change and ready for someone who articulated a different vision for the nineties and the decade beyond."

"I feel a deep sense of gratitude because there were a number of people in the medical community, who along with other groups, were really the main source of support I had throughout the campaign," said Klug. "AMPAC, and its Wisconsin counterpart, WISPAC, were very helpful in the end when they delivered money for commercials. In a media market like Madison, that money can really make the difference between saturating the airways or having a hard time getting your message across."

Editor's note: Since this interview, Scott Klug was appointed to the Education and Labor Committee and the Government Operations Committee. During this interview the Madison Republican had indicated that these were his top two choices. ❑

Healing the healer: a primer on physician impairment

David G. Benzer, DO, Wauwatosa

PHYSICIAN IMPAIRMENT was defined by the AMA in 1973 as "The inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including alcoholism or drug dependence."[1] Despite general agreement among physicians that the term "impaired" is less than optimal, use of the phrase remains widespread into the 1990s. While the increasing popularity of phrases such as "physician health" and "physician well-being" have failed to replace the word "impaired," these alternatives have succeeded in emphasizing the overall positive aspects of physicians helping their colleagues to re-achieve health following illness and to successfully return to medical practice.

This review will update the etiologies of physician impairment, with special emphasis on chemical dependency, which remains the leading cause of impairment in physicians. The evolution of the SMS Statewide Impaired Physician Program (SIPP) will be discussed as a model of organized medicine's response to physician impairment at the level of the state.

While much has been accomplished in recognizing and treating impairment in physicians, there remains work to be done. Goals and aspirations for the future will be discussed with a special challenge to the individual physician, hospital medical staffs, medical schools, and residency training programs. Awareness, willingness, and caring enough to act remain the requirements for continued success in recognizing and treating physician impairment.

Dr Benzer is director of the SMS Statewide Impaired Physician Program and chair of the SMS Alcoholism and Other Drug Abuse Committee. Reprint requests to: David Benzer, DO, c/o ADMC, 1220 Dewey Ave, Wauwatosa, WI 53213. Copyright 1991 by the State Medical Society of Wisconsin.

Etiologies of impairment

Some significant changes have occurred in the past 5 years in recognizing the multiple origins of impairment in physicians. While chemical dependency remains the leading cause of impairment,[2,3] other etiologies are being recognized.

Impairment due to mental illness without concurrent chemical dependency accounts for between 6%-20% of the cases reported to state physician health programs, including Wisconsin.[2,3,4] It is unclear whether these numbers reflect a lesser incidence of psychiatric illness as the source of impairment in physicians as compared to chemical dependency, or less willingness on the part of colleagues to report physicians with psychiatric illness to state programs. What is clear, is that within this group of psychiatrically ill physicians comes the tragic individual cases of suicide. Physician suicide occurs at a frequency of between 28 and 40 per

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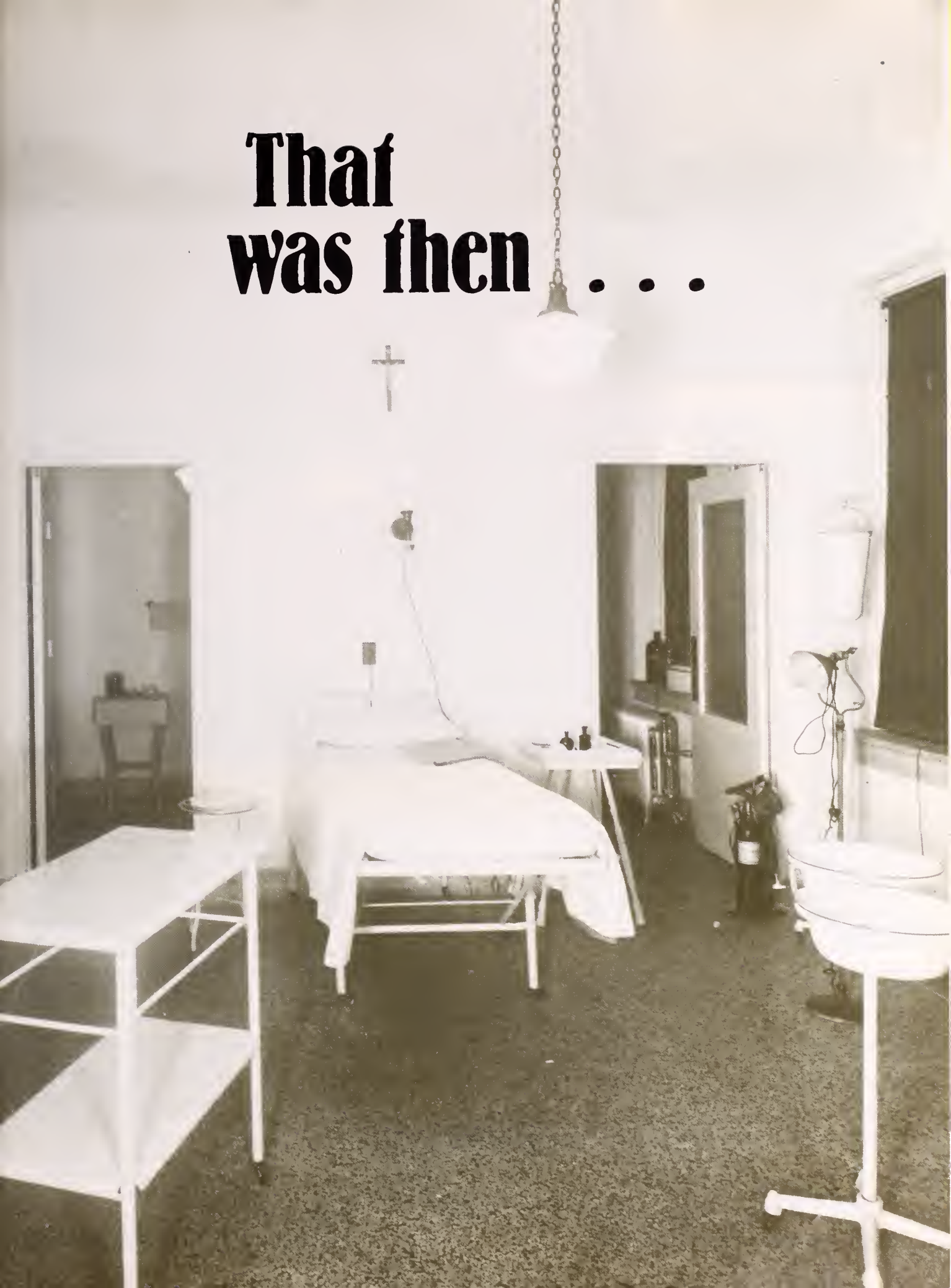

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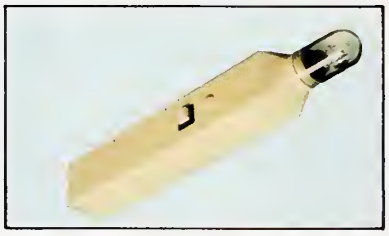

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Continued from page 70
100,000, (compared to the rate of 12.3 per 100,000 in the general population).[5] Much work needs to done to enhance early recognition and thereby prevent physician attrition due to mental illness.[6]

Cognitive impairment due to neurologic disease or senility secondary to aging can result in impairment in a physician's ability to practice medicine.[7] Few data are available regarding the incidence of cognitive impairment in physicians, but cases are being reported to state physician health program including Wisconsin's SIPP.

Despite the fact that the AMA's definition of physician impairment includes a reference to physical illness, the preponderance of medical literature on this topic fails to mention cases of physical illness as the cause.[8] While it has been estimated that 4% of this country's physicians suffer from physical disability, these physicians seldom come to the attention of state impaired physician health programs.[9] Nevertheless, physicians need to be aware of physical disability resulting in the inability to practice medicine with "reasonable skill and safety" and intervene to help that colleague regain an effective medical practice.

In the recent past, a discussion of addiction in physicians would have been limited to chemical dependency. At this time, the spectrum of addictive disorders has been expanded to include compulsive gambling, eating disorders, and compulsive sexual behavior. "Sexual addiction," essentially referring to the accrual of negative consequences as a result of compulsive sexual activity, is a concept popularized by Carnes in 1983.[10] The possibility that some cases of sexual misconduct by physicians, including sexual violation of the physician-patient relationship, may be a result of impairment by virtue of a treatable compulsion is gaining acceptance.[11] Many state physician health programs, including Wisconsin's, will accept cases of physician impairment that are related to sexual misconduct. Protocols are being developed to provide treatment, monitor recovery, and assist physicians with this problem to regain their credibility.[11] This dramatically differs from the exclusively punitive approach that had characterized the response to this problem over the years.

Another problem which has the potential to impair a physician's ability to practice medicine effectively occurs as a result of erosion of the doctor's equanimity by stressors which he or she is unable to effectively cope with. Such stressors include long working hours, the need to keep abreast of new developments in medicine, and the problems arising from the often conflicting needs of profession and family. The result can be what we have termed "stress impairment syndrome."

State physician health programs, including Wisconsin's SIPP, are being referred physicians whose medical practice is being affected by the Stress Impairment Syndrome. Symptoms of stress impairment include:

- frequent use of profanity,
- an inclination to blame others for mistakes,
- procrastination about decisions,
- a self-imposed increase in working hours,
- increase in self pity,
- reluctance to relax,
- dietary extremes,
- further deterioration in handwriting,
- erosion in interpersonal relationships, and
- disrupted sleep patterns.

As the inability to effectively cope with stress progresses, more symptoms emerge. Ultimately, the physician's medical judgment may be adversely affected. An inability to make clinical decisions seems to be a late manifestation of the Stress Impairment Syndrome. Since stress impairment is the most preventable of these sources of physician impairment, much can be done by organized medicine at the level of the hospital, county medical society, and state to provide educational programs to help teach physicians the skills necessary to avoid consequences from inadequately coping with stress. The same needs to be done at the level of medical schools and residency training programs. State physician health programs can serve as a resource for physicians with stress-related impairment and assist in finding effective treatment as well as longitudinally monitoring response to that treatment.

While all of these disparate etiologies of impairment combined probably do not equal chemical dependency in terms of incidence, it is important that physicians broaden their understanding and definition of impairment to include these potential threats to effective and safe medical practice. At the same time, national, state, and local physician health programs need to be aware of new developments in identifying, treating, monitoring, and providing advocacy for physicians whose ability to practice medicine is impaired.

Chemical dependency

For years chemical dependency has been synonymous with physician impairment, although this provincial view is slowly changing as noted above. Even so, chemical dependency remains the illness affecting the overwhelming majority of physicians reported to, and active in, the SIPP. Currently, 82% of physicians active in the SIPP are involved because of problems related to the use of alcohol or other drugs.

The incidence of chemical dependence in physicians is unknown: reliable epidemiological data are unavailable. The lifetime incidence of addiction to alcohol in the general population is estimated to be 10% in men and 5% in women.[12,13] Since alcohol is the drug most frequently abused by physicians entering treatment,[14] and

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since narcotic addiction occurs more frequently among physicians than in the general population,[14,15] we might expect that chemical dependency is not found any less often in physicians than in the general population.

Chemical dependency can be defined as a biogenetic illness whereby vulnerable individuals, as a direct result of using mood-altering drugs (particularly sedatives, narcotics, stimulants), develop life problems. These life problems usually do not serve to effectively and permanently modify the use of drugs, thereby paving the way to a recurrence of the problems. All life spheres may be affected by the drugs including family, social, occupational, and health. One would think that a relatively common illness that is capable of disrupting multiple life areas including occupation, would result in a large number of physicians across this country being identified and treated for chemical dependency. Unfortunately, this is not the case. There exist a number of formidable barriers to recognizing and subsequently treating this disorder in physicians.

Barriers to recognizing dependency

Lack of training in addiction. A clinician's ability to recognize any disease requires an index of suspicion for that disease which includes being aware of the signs and symptoms characteristic of the disorder. Unfortunately, many physicians have not been trained to recognize addiction, especially the earlier signs and symptoms. This is being rectified by expanding curriculums in addiction medicine in medical schools and increasing opportunities for continuing medical education hours in addiction medicine being offered to practicing physicians.

The sequential progression of impairment. Addiction usually follows a predictable progressive course of sequential effects.[16] The effects of the chemical dependency are usually felt first by the family, next by the larger social circles of the community, and finally in the workplace. Physicians effectively mask their evolving addiction from colleagues in the office or hospital. It is usually not until late in the course of the disease that the effects are felt in the workplace.

Denial by colleagues. Often the first response of colleagues and staff when problems due to addiction occur in the professional setting is to either ignore obvious signs of impairment, often with the help of rationalization such as "It's probably just fatigue," or to cover for the addicted individual's deficiencies such as unexplained absences from the office or hospital. This combination of ignoring or covering up for impairment in medical practice on the part of colleagues, allied health professionals, and office and hospital personnel, results in the so-called conspiracy of silence. This, unfortunately, allows the addiction to progress, and the doctor to become even sicker. Also, with the progression of the disease comes an ever-increasing chance of patient care being compromised.

Denial by the impaired doctor. Herrington called denial in addiction "the cardinal symptom of the disorder."[17] The defensive system of the chemically-dependent physician incorporates denial with rationalizations, projections, and delusions which shield the affected doctor from clearly seeing the illness. These defenses also make it difficult for others trying to express concern and to get their message of concern through to the doctor.

Despite the many barriers to identifying in colleagues impairment due to addiction, the responsibility to do so remains. The following indicators of impairment which mirror the sequential impact of addiction in the life of the physician, provide some suggestions on what to look for.

Recognizing the dependent physician

Family.
- Isolation from family, withdrawal from family activities.
- Wide mood swings noted by family, often including hostile or belligerent behavior that may lead to verbal or physical abuse of spouse or children.
- Prolonged absences from home.
- Marital disruption: conflict, separation, and divorce.

Community.
- Withdraws from community activities.
- Embarrassing behavior at social functions due to intoxication.
- Loss of friendships within the community.
- Arrests for operating a motor vehicle while intoxicated.

Health.
- Deterioration in appearance.
- Signs of intoxication or withdrawal.
- Medical complications of addiction.
- Emotional crises and mood swings.

Office.
- Arriving late, leaving early.
- Isolating in office.
- Mood swings noted by staff such as being argumentative with staff.
- Patient complaints to staff regarding doctor's behavior.
- Inappropriate orders.
- Inappropriate prescribing of controlled substances.

Hospital. (All signs of advanced illness.)
- Making rounds at inappropriate times.
- Inappropriate orders.
- Inappropriate response to calls from nursing staff, emergency room, etc.
- Evidence of poor judgment and patient management.
- Geographic escape: Moving of

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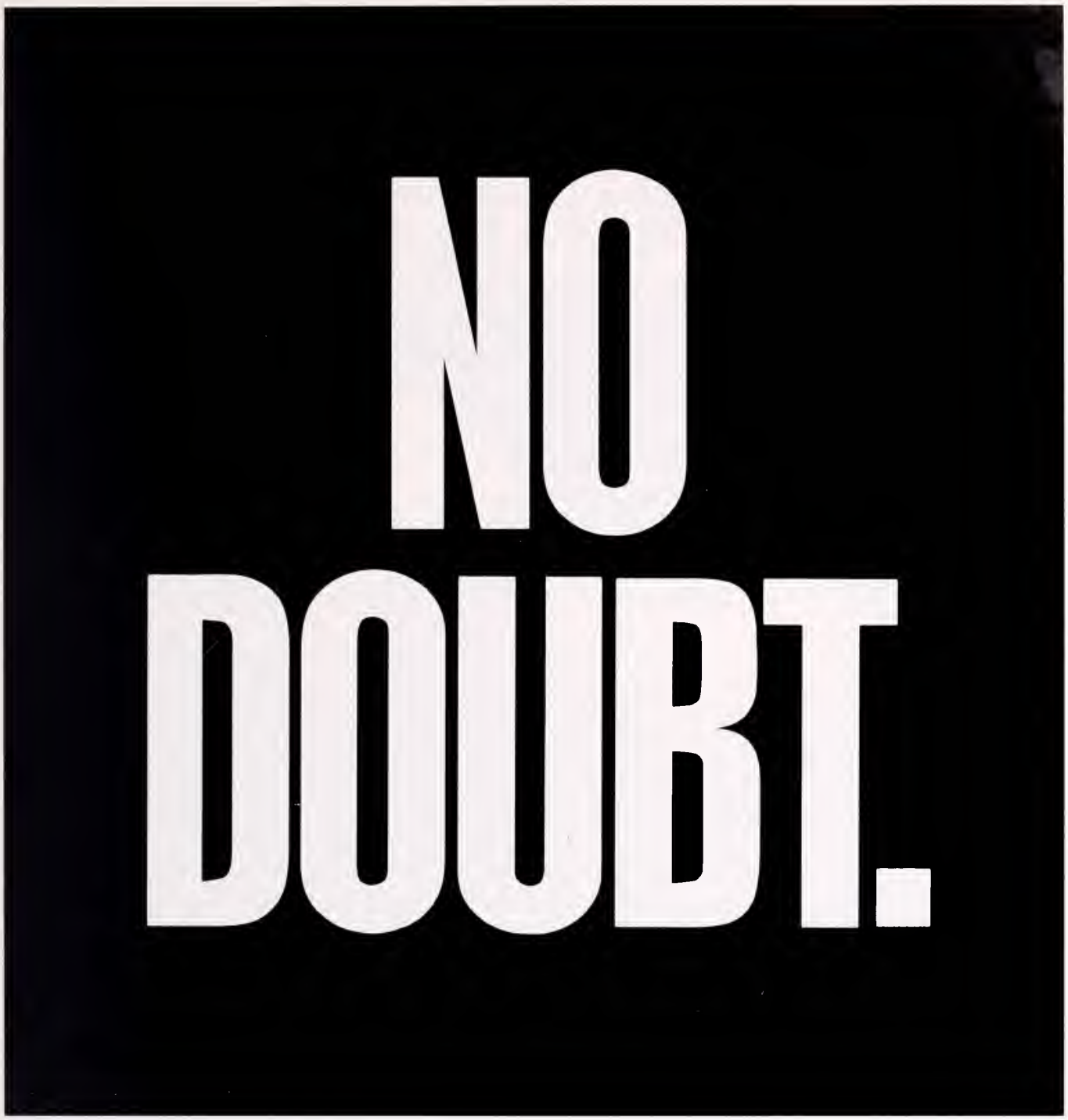

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practice from one hospital to the next hoping to avoid confrontation.

No two cases of addiction in physicians present the same; each doctor's illness presents a new challenge of identification for colleagues. The guidelines presented here will not be helpful in all cases but are offered as possible indicators of impairment.

Intervention

Once recognized, impairment in a physician needs to be brought to the attention of that physician. While insulated by denial and other defenses, the physician suffering from chemical dependency or other type of impairment often is not pleased to hear of these concerns. Therefore, there are some proven techniques that can improve the chances of successfully communicating concern to a colleague. The process is known as intervention.

Unlike the intervention process developed by Vernon Johnson,[18] in which family members play a central role, intervention with physicians when carried out by associates in clinical practice, hospital staff, or at the level of organized medicine, usually involves only colleagues in medical practice.[19]

Some of the principles of intervention by peers which may enhance the outcome of the process are as follows:

Basic principles.

- Multiple participants (at least two).
- Appropriate timing.

  Intervention should not be done when the doctor is intoxicated. Intervention should be done as soon as possible after a crisis that is precipitated by the impairment.
- Selecting interveners.

  Individuals with a knowledge of specific consequences of the addiction or specific documentation of impairment who can be rational, non-judgmental, and sympathetic should be selected as interveners.
- Location of intervention.

  A quiet non-threatening private site should be selected for the intervention. These do not include hallways, hospital corridors, or doctors' lounges.
- Anticipate possible reactions.

  Interveners should expect that the doctor will not be pleased to hear these concerns. Anger, defensiveness, sadness, or shame can better be dealt with by the interveners if they are anticipated.
- Preparing the intervention.

  The interveners should prepare themselves prior to the intervention, which includes listing specific examples of impairment, deciding who should say what, and deciding what is to be expected of the doctor being intervened upon. Recommending evaluation or assessment of the doctor is a satisfactory goal of intervention. This prevents the interveners from being accused of making a diagnosis from afar. It should be made clear that it is expected that the impaired doctor will also comply with any recommendations made by the consultant physician.
- Demonstrate genuine concern.

  This is the optimal response to the defensiveness that may be evoked in the impaired doctor. It needs to be evident to the doctor that the interveners are being motivated by care and concern. If there are ulterior motives, these will be quickly perceived by the doctor and the effectiveness of the intervention will be lessened.
- Understanding the causes of impairment.

  Effective interveners should understand the basics of the illness that they are confronting. In the case of chemical dependency, interveners need to be aware of the signs and symptoms, as well as the progression of the disease. Conversely, if the intervention team is unaware and immersed in old moral models of addiction, then the chances of success will be lessened. The impaired doctor will perceive this judgmental attitude and become even more defensive and less likely to clearly hear the specific problems that are being shared.
- Present alternatives.

  The desired outcome of the intervention should be decided in advance. It is critical to always give the physician a number of options for assessment and treatment. The SIPP provides four to six alternatives to each doctor. This invokes a cooperative spirit and helps lessen feelings of being coerced.

  Conversely, it is important the intervention team not accept suggestions for evaluation and treatment proposed by the doctor. This runs the risk of turning the critical role of initial evaluator over to a non-objective individual or one who may not be experienced in evaluating physician impairment.

At this juncture of the intervention, it is crucial to provide some hope for the doctor. Highlighting that the purpose of the intervention is to save a medical career, not destroy it, and that it is expected by the interveners that the doctor will promptly address these concerns and then return to medical practice, will help establish the tone of rehabilitation rather than punishment.

Many physicians are the recipients of family intervention, obviating the need for colleagues to respond. In those instances where the impairment progresses to the point where it affects medical practice, however, it is incumbent upon colleagues to act to protect the interest of the public, of the medical community, and most important the doctor and his or her mental and physical well-being. Medical clinics and hospitals should have resources developed and ready to respond when the need arises. Physician health committees at the local level must play a critical role if we are to succeed in early recognition of impairment in physicians.

Continued on page 78

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Continued from page 76

Evaluation and treatment

Evaluation of the physician who is mentally ill should be accomplished by a psychiatrist who is experienced in evaluating physician impairment. Similarly, suspected chemical dependency should be evaluated by a physician with a background in addiction medicine, as well as in the treatment of chemically-dependent physicians. A number of treatment programs offer evaluation services that are specifically geared toward physician impairment. When treatment is needed and is recommended, there has traditionally been an inpatient bias for treating chemically dependent physicians. The basis of this bias, still valid today, is as follows.

Inpatient treatment bias.

- Inpatient settings provide the intensity of treatment to help dismantle sophisticated denial systems often present in chemically-dependent physicians.
- Inpatient treatment provides a differential diagnosis to discover possibly coexistent illnesses such as psychiatric illness in addition to the chemical dependency.
- Inpatient treatment helps facilitate the transition in roles from caregiver to care-recipient.
- Inpatient treatment reassures the public that a prompt response to suspected impairment has been initiated. When the doctor gets well he or she will then return to practice.

Within the SIPP, the Program Managing Committee has learned over the years that a more satisfactory response to treatment is achieved when physicians receive intensive treatment at facilities which espouse a physician-directed medical model of therapy for addiction. Within this accepted model of treatment, the SMS SIPP expects these minimum requirements for successful treatment of physician addiction.

SMS SIPP treatment expectations.

- Thorough physical examination including neuropsychiatric evaluation.
- Frequent, if not daily, direct contact with physician-therapist.
- Individual counseling, frequency determined by the physician-therapist.
- Group counseling.
- Regular attendance at Alcoholics Anonymous (AA) or similar self-help groups is strongly encouraged. The frequency of these meetings is to be determined by the physician-therapist. Professional AA meetings, if at all possible, should be used.
- Random, witnessed urine drug screens, at a frequency determined by the physician-therapist.
- Use of a recovery home or halfway house, which may be indicated following inpatient treatment.
- Use of a standard aftercare agreement with the program managing committee.
- Aftercare treatment plan for a minimum of 2 years after completion of primary treatment.
- Direct conferences with the physician-therapist on a regular basis, as prescribed.
- Individual and group counseling at the facility and in the physician's community, as arranged under the direction of the physician-therapist.
- Statewide program monitoring of the physician's progress in recovery over the post-hospital period by way of the aftercare agreement. Through this agreement, medical therapists are authorized to provide periodic written reports to the program managing committee.

Aftercare and monitoring

Following completion of primary treatment for impairment, all physicians should enroll in an aftercare and monitoring program as noted above. This is certainly in the best interest of the public and peers in medical practice. The reassurance that the recovery of the doctor is being objectively scrutinized is important. It is also critical, however, to the recovering doctor that this be in place. A monitoring program serves to document the recovery of the physician. Problems–which do arise–with state medical licensure, hospital privileges, and malpractice insurance coverage can be more easily solved if the recovering physician is in a monitored aftercare program. Components of a monitored aftercare program are listed above.

The role of the SMS SIPP

Since its inception in 1977, the SMS SIPP has served as a resource for helping impaired physicians in Wisconsin and has been a model of organized medicine's response to physician impairment. The program's genesis and early evolution was documented by Kempthorne in 1971.[20] Further evolution of the program was detailed by Adams in 1988.[21] Today, the SIPP serves as a resource first and foremost to help facilitate interventions, evaluations, and if necessary, treatment for impaired physicians in Wisconsin. Following treatment, the program provides advocacy for reentry to medical practice. In addition to this, the program provides the following services.

- A confidential toll-free number for concerned individuals to share their concerns regarding a potentially impaired physician.
- Education and outreach including a speakers bureau to provide informative presentations on the subject of physician impairment including prevention, intervention, treatment, monitoring, and reentry issues.
- Intervention training for physicians interested in working as part of the SMS-SIPP intervention teams is available. This training familiarizes volunteers with the multiple etiologies of impairment and techniques for successful intervention.

Conclusion

Much progress has been made in helping physicians regain health following impairment. Enhancing our recognition of the multiple etiologies of impairment has allowed more physicians to be identified as needing assistance. The evolution of treatment and monitoring protocols has facilitated the reentry of treated physicians into medical practice. Barriers that in the past have made reentry difficult are continuing to fall as a result of the increased uniformity of treatment and monitoring expectations across the country. Clinics, hospitals, and medical examining boards are learning that standard treatment and monitoring protocols such as those used by the SIPP are effective in providing a favorable prognosis for recovery, as well as the documentation necessary to validate that recovery.

Despite the progress that has been made, there is still much to be accomplished. Each physician needs to recognize that he or she must share in the responsibility of recognizing impairment in colleagues as early as possible and be willing to reach out to help.

Ideally, each hospital would have a physician health committee whose role would be to provide information on prevention, intervention, and treatment of the illnesses that may impair a physician's ability to practice medicine. The committee can also serve as a communication link between the medical staff and other health-care providers in the hospital setting so that their concerns can be heard in a safe, confidential manner. Finally, physician health committees can play a role in acquiring and maintaining documentation necessary as part of the reentry process of physicians who have had treatment for some impairment.

Every county medical society should regularly plan an educational program on recent developments in physician impairment. This provides physicians with a regular reminder of their role in this process.

Medical schools and residency training programs should have student and resident assistance programs. These programs can provide prevention services, assistance when evaluation or treatment is needed by a student or resident, and help in facilitating reentry to programs following treatment. If assistance programs are in place during the training years, then once in practice, physicians should be more comfortable with physician health programs at the local or state level.

While much remains to be accomplished, optimism should remain high. The medical profession has a long history of meeting the challenges it faces. The challenge of providing help for colleagues whose ability to practice medicine is impaired is proving to be no exception.

References

1. Council on Mental Health: The sick physician: Impairment by psychiatric disorders including alcoholism and drug dependence. *JAMA* 1973;223: 684-687.
2. Gualtieri A, Consertino J, Becker J. The California experience with a diversion program for impaired physicians. *JAMA* 1983;249:226-229.
3. Shore J. The impaired physician four years after probation. *JAMA* 1982;248:3127-3130.
4. Shore J. The Oregon experience with impaired physicians on probation. *JAMA* 1987;257:2391-2934.
5. Council on Scientific Affairs: Results and implications of the AMA-APA physician mortality project—Stage II. *JAMA* 1987;257:2949-2953.
6. Thapar A. Psychiatric disorder in the medical profession. *Br J Hosp Med* 1989;42:480-483.
7. Mason S. Organic mental disorders and the issue of retirement. *Mi Med* 1988;87:329-334.
8. Wainapel S. The physically disabled physician. *JAMA* 1987;259:2935-2938.
9. Lewis S. The physically handicapped physician, in Callan J: The physician: A professional under stress. Appleton-Century-Crofts 1983;318:326.
10. Carnes P. Out of the shadows: Understanding sexual addiction. CompCare Publishers 1983.
11. Irons R. Contractual provisions for working with physician sexual addicts. *Am J Prev Psychiatry* 1990;2(3):48-50.
12. Barcha R, Steward M, Guze S. The prevalence of alcoholism among general hospital ward patients. *Am J Psychiatry* 1968;125:133-136.
13. Schuckit M. Alcohol patterns and problems. Rutgers University Press 1985.
14. Talbott G, Gallegos K, Wilson P, et al: The Medical Association of Georgia's impaired physicians program. *JAMA* 1987;257:2927-2930.
15. Herrington R, Benzer D, Jacobson G, et al. Treating substance use disorders among physicians. *JAMA* 1982; 247:2253-2257.
16. Pauwels J, Benzer D. The impaired health care professional. *J Fam Pract* 1989;29:477-484.
17. Herrington R. Chemical dependency in physicians. *Wis Med J* 1982;81(4):27-30.
18. Johnson V. Intervention. Johnson Institute Books 1986.
19. Crosby L, Bissell L. To care enough: Intervention with chemically dependent colleagues. Johnson Institute Books 1989.
20. Kempthorne G. Impaired physician update–1981. *Wis Med J* 1981;80(2):12-13.
21. Adams T. A new approach to impaired physicians. *Wis Med J* 1988;87(8):3-4.❑

Correction

On page 38 of the January 1991, *Wisconsin Medical Journal*, Joan Harrington, DPM, and John LeRight, DPM, were incorrectly identified as MDs. The *WMJ* apologizes for the error and any inconvenience that may have occurred as a result. ❑

Public Health

Project SENSOR: Wisconsin surveillance of occupational carpal tunnel syndrome

Lawrence P. Hanrahan, MS; Dee Higgins, RN; Henry Anderson, MD; Linda Haskins; and Simon Tai, PhD, Madison

OUR MODERN SOCIETY is founded on increasingly complex industrial processes. While virtually all industries are experiencing greater automation, manual labor has not been eliminated. For many workers, an eight hour work shift means highly stereotypic, manual tasks repeated hundreds if not thousands of times while working with machines, hand tools, and on assembly lines. When these biomechanical stresses accumulate beyond a worker's adaptive limits, a repetitive trauma disease may result. One such disorder is carpal tunnel syndrome.

Background

Carpal tunnel syndrome (CTS) is a compression neuropathy of the median nerve at the wrist.[1] It is a fairly common disorder having many etiologies.[1-4] CTS is characterized by symptoms arising in the distribution of the median nerve to the hand, including "paresthesias, pain and numbness in the palmar side of the thumb, index finger, middle finger, and radial half of ring finger; and the dorsal side of the same digits distal to the proximal interphalangeal joint, and radial half of the palm."[2] Additionally, weakness and atrophy of the thenar muscle can occur.[1-3] Sensory manifestations often precede muscle weakness and symptoms are frequently more severe at night.[1,3]

Non-occupational factors jeopardizing the median nerve through compression or ischemia include diabetes, pregnancy, rheumatoid arthritis, and gout.[3,5] Work-related carpal tunnel syndrome is caused by cumulative biomechanical stresses on the hands and wrist.[2,3,5] Silverstein[5] identified six occupational causes:

- repetitive movements of the wrists or fingers with loading of the tendons in the carpal tunnel;
- forceful contraction of these tendons;
- extreme flexion or extension of the wrist, pinching or other awkward postures;
- mechanical stresses over the course of the median nerve of the hand;
- exposure to vibration; and
- the use of poorly fitting gloves, and exposure to cold. Occupations with combinations of factors are at greater risk than jobs with only one risk factor.[5]

Occupational disease surveillance is hampered because of inadequate information systems, multiple etiologies, and unrecognized occupational disease: clinicians fail to record a work history, and then cannot possibly link the disease to the workplace.[6] Under the Sentinel Event Notification System for Occupational Risks (SENSOR) program,[2,7] Wisconsin is developing a pilot CTS surveillance program by obtaining physician case reports, and Workers Compensation (WC) CTS cases. Since January 1989,

Continued on page 82

From the Research and Surveillance Unit, Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Hanrahan is the supervisor of the unit; Higgins is the SENSOR Project Coordinator; Dr Anderson is chief of the section; Haskins is the public health educator; Dr Tai is the director for the Bureau of Compensation Performance, Workers Compensation Division, Department of Industry, Labor, and Human Relations. This project was made possible through grants from the National Institute for Occupational Safety and Health, and in cooperation with the Agency for Toxic Substances and Disease Registry, US Public Health Service. Copyright 1991 by the State Medical Society of Wisconsin.

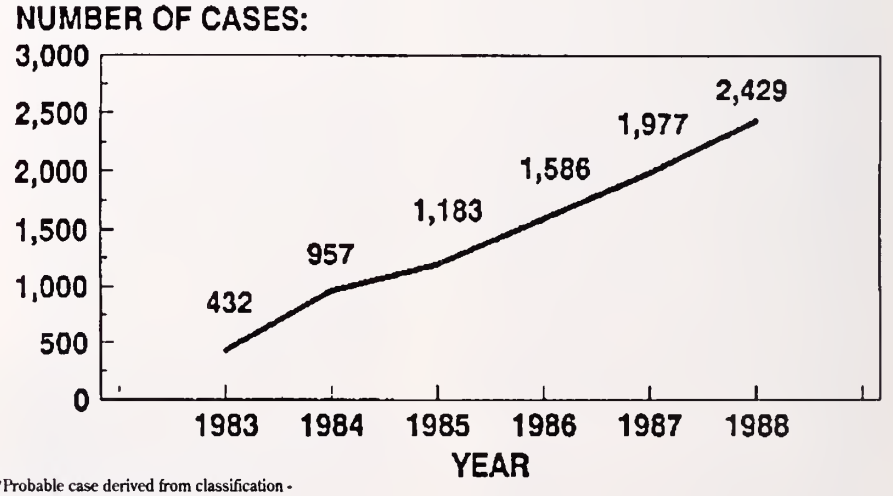

Fig 1.–Wisconsin Workers Compensation carpal tunnel syndrome cases, 1983-1988 (n=8595).*

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17 physicians have reported occupational CTS using the SENSOR case definition.[2,7] Since January 1988, the computerized WC file has been routinely accessed to search for CTS cases.

Workers compensation surveillance

Since 1983, Wisconsin has seen more than a five-fold increase in the reporting of WC-CTS cases. WC-CTS cases have risen from 432 per year in 1983 to 2,429 in 1988, representing an increase from approximately 2.5 cases to 11.5 cases per 10,000 workers annually (Fig 1).

Meat packing and poultry processing industries demonstrated the greatest elevated WC-CTS risk (Fig 2). These risks are over 10 times the all industry average of seven cases per 10,000 workers for the entire time period. Other risk elevated industries included the manufacture of motor vehicle car bodies, and internal combustion engine manufacturing.

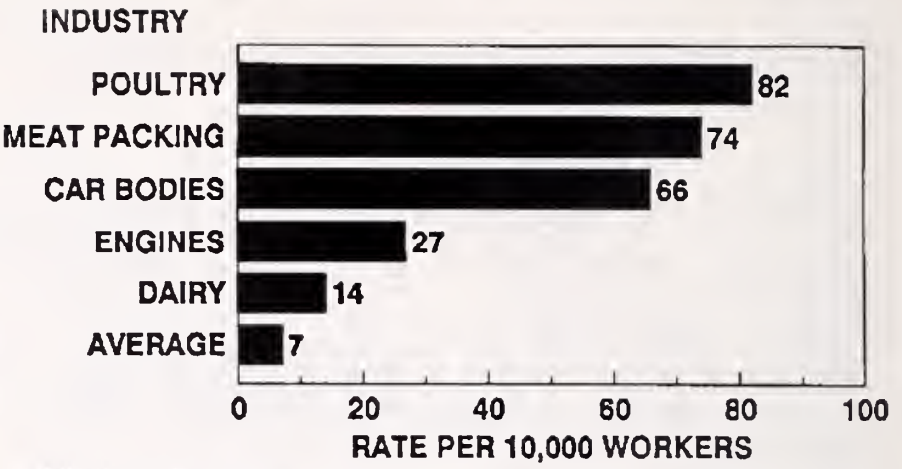

Fig 2.–Wisconsin Workers Compensation carpal tunnel syndrome cases by industry, 1983-1988.*

Occupations in which highly repetitive, manual tasks predominate were at highest risk (Table 1). Dental hygienists and data entry keyers were at greatest risk. Electronic equipment assemblers, hand cutting occupations, sewing machine operators, assemblers and butchers all experienced an increased risk for WC-CTS.

A total of 82% of the WC-CTS cases were settled as of March, 1990. These cost more than $33 million for compensation and medical benefits. These averaged $4,700 each, with $1,400 for medical treatment costs. Average medical costs are most likely underestimated because, in many cases, all of the medical changes are not reported to the WC system.

Table 1.–Wisconsin Workers Compensation carpal tunnel syndrome* case-referent analysis of high risk occupations, 1983-1988 (n=8,595).

Occupation	No. of cases	Odds** ratio
dental hygienists	26	15.5
data entry operators	60	12.2
electronic equipment assembler	22	9.6
hand cutting occupations	148	7.4
hand grinding	52	5.8
sewing machine operator	128	5.6
misc. hand working occupations	212	4.8
assemblers	1310	4.2
hand packagers	337	3.3
metal and plastic processors	63	2.9
butchers and meat cutters	212	2.8
package machine operators	101	2.1
grinding machine operators	146	1.9
misc. machine operators	358	1.7
slicing machine operator	125	1.7

*Probable case derived from classification-disease of peripheral nervous system at the wrist and case reviews.
**Ratio of odds of occupation in case series v odds of occupation in referent series (all other workers compensation cases). Odds ratio greater than 1 increases CTS risk.

SENSOR CTS surveillance

Since January 1989, 300 occupational CTS cases have been reported by physicians to the SENSOR program. In 54% of the cases, diagnosis indicated bilateral involvement; 35% were limited to the right upper extremity. Many high risk WC-CTS industries were also found in the SENSOR-CTS series (Table 2). Job characteristics were noted, and 72% of the cases were found to have highly stereotypic, repetitive movements. Twenty-one percent were characterized by forceful use of the hands, 14% had awkward postures, and 13% required a pinch grip.

Comment

There has been a dramatic increase in occupational CTS in Wisconsin as

reported through Workers Compensation. These and the SENSOR CTS cases predominate in industries and occupations requiring highly repetitive and forceful manual tasks. CTS cases have been very costly for both employers and employees.

There are many possible reasons for the increased case load. These include better recognition, reporting, and treatment; the aging of the work force into higher risk age groups; increased productivity demands, and changing job tasks as industrial processes evolve.

Occupational CTS is preventable. Because it is caused by workplace biomechanical hazards, their reduction and elimination can reduce CTS incidence.[4,5] Ergonomic control measures are the foundation for CTS hazard elimination.[3-5]

Because surveillance involves the analysis and dissemination of health information to those who need to know, the Wisconsin Division of Health conducted three seminars on CTS prevention strategies in 1990. Two more are planned for 1991. The seminars have reached over 500 individuals, including health care providers, and over 131 employers from high CTS risk industries.

Increasingly, physicians will be asked to provide comprehensive medical management of cases as CTS concern grows. When CTS is caused by a workplace, it is important to remember that unless underlying work conditions are addressed, any medical treatment, including surgery, cannot be expected to provide permanent relief.

Table 2. – Wisconsin SENSOR occupationally induced carpal tunnel syndrome case frequency by industry, January 1989-September 1990 (n=188 industry coded cases).

SIC* code	Industry	No. of cases	%
35	machinery mfg	31	16
30	rubber and plastics	25	13
80	health services	11	6
33	primary metal mfg	11	6
20	food products	9	5
36	electronic equipment mfg	8	4
23	apparel mfg	7	4
17	specialty construction	6	3
26	paper products mfg	5	3
22	textile mills	4	2
37	motor vehicle equipment mfg	4	2
54	grocery, food stores	4	2
24	lumber and wood products	4	2

*Standard industrial classification, 2-digit.

Series coordinators

The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, are coordinating this series for the *Wisconsin Medical Journal.* Physicians desiring to learn more about occupational carpal tunnel syndrome and its prevention are encouraged to attend the seminars sponsored by the Wisconsin Division of Health. Continuing medical education credits will be granted. For more information, contact Dee Higgins, RN (608-267-3256).

Acknowledgements

The authors appreciate the assistance of Patrick Remington, MD, in reviewing drafts of this manuscript.

References

1. Phalen GS. The carpal tunnel syndrome. Seventeen years experience in diagnosis and treatment of 654 hands. *Am J Bone and Joint Surg.* 1966;48(2):211-228.
2. Baker EL, Ehrenberg RL. Preventing the work-related carpal tunnel syndrome: Physician reporting and diagnostic criteria. *Ann Intern Med.* 1990;112(5):317-319.
3. Feldman RG, Goldman R, Keyserling WM. Classical syndromes in occupational medicine: Peripheral nerve entrapment syndromes and ergonomic factors. *Am J Ind Med.* 1983;4:661-681.
4. Putz-Anderson V, ed. *Cumulative trauma disorders: A manual for musculoskeletal disorders of the upper limbs.* London: Taylor and Francis; 1988.
5. Silverstein BA, Fine LJ, Armstrong TJ. Carpal tunnel syndrome: Causes and a prevention strategy. *Seminars in Occupational Medicine.* 1986;1:213-221.
6. Pollack ES, Keimig DG, eds. *Counting injuries and illnesses in the workplace: Proposals for a better system.* Washington, DC. National Academy Press; 1987.
7. Anderson HA, Higgins D, Hanrahan LP. Project SENSOR: Occupational disease and injury surveillance. *Wis Med J.* 1989;88(12):35-38. ❑

HMO financial reports

The year-end statements for the second quarter of 1990 for Wisconsin's HMOs are outlined in the following chart. The report was provided by the Office of the Commissioner of Insurance (OCI). Numbers do not tell the whole story, so physicians requiring further information should contact either the OCI or the chief financial officer of the HMO in question.

Recognizing that the report does not give physicians current or perfect information on the HMOs financial performance or stability, and that recent legal changes have increased the incentive for HMOs to enter into hold harmless agreements with physicians, the SMS sought to provide greater accountability of HMO administrations to their contracting physicians.

WMJ will publish the quarterly financial statements of Wisconsin HMOs and future articles explaining the hold harmless law and how best to respond to it.

Office of the Commissioner of Insurance HMO 1990 annual statement summary–2nd quarter–unaudited

	Total Assets	Total Liabilities	Net Worth	Total Revenue	Total Expenses	Net Income	Enrollees
Aetna	2,840,044	2,266,897	630,050	5,875,591	6,745,458	(574,113)	10,463
Compcare	20,207,039	13,764,161	6,442,878	80,260,432	79,380,129	710,800	151,996
Dean	30,526,390	21,276,157	9,250,233	58,961,576	53,908,945	3,032,910	97,662
Family	43,096,124	22,455,926	20,640,198	51,686,284	49,589,156	2,097,128	83,946
GHC-EC	3,894,368	2,947,034	947,334	9,041,036	8,888,164	152,872	14,401
GHC-SC WI	11,508,877	7,753,030	3,755,847	18,148,715	16,706,674	1,442,041	34,702
GLHP	1,259,860	670,861	588,999	2,003,140	2,054,184	(51,044)	4,395
HMO Midwest	2,834,842	2,034,413	800,429	6,135,295	5,834,866	300,429	8,784
HMO of WI	7,804,370	5,093,099	2,711,271	20,411,452	19,481,957	569,495	36,231
Maxicare	5,714,835	3,028,631	2,686,204	11,798,525	12,115,269	(316,744)	20,001
Med Assoc	835,463	112,971	722,492	1,878,823	1,727,055	151,768	2,837
Metlife	1,886,037	1,162,681	723,356	1,842,458	2,231,314	(391,856)	2,217
Midelfort	4,437,832	2,938,024	1,499,808	13,862,515	12,893,030	584,385	22,867
Network	3,888,322	2,978,646	909,676	12,917,730	12,686,698	136,041	24,017
NCHPP	10,458,870	6,057,505	4,401,365	17,287,133	16,212,386	1,074,747	30,125
Phys Plus	5,925,982	3,753,444	2,172,538	35,019,702	34,628,867	240,935	58,426
Primecare	23,451,012	19,905,861	3,545,151	52,526,785	53,438,025	(1,081,439)	100,064
Samaritan	16,859,853	12,224,344	4,365,509	39,844,772	39,907,994	(93,222)	74,813
Security	21,444,655	15,223,502	6,221,153	42,844,235	42,024,549	819,686	74,993
U-Care	4,773,719	3,323,606	1,450,113	7,468,189	6,727,136	741,053	13,523
United	2,550,521	2,275,447	275,074	7,749,920	8,153,564	(403,644)	16,433
WHOIC	21,832,583	16,832,756	4,999,827	59,811,293	57,138,795	1,696,448	113,669
EHIC	N/A	N/A	N/A	17,794,688	17,619,612	(175,076)	30,271
Q-Care	N/A	N/A	N/A	5,983,972	5,842,587	141,385	10,051
Allhealth	N/A	N/A	N/A	1,632,014	1,620,023	11,991	2,040
WHPP-EC	N/A	N/A	N/A	1,901,820	2,225,726	(323,906)	2,223
WHPP-Gr Bay	N/A	N/A	N/A	14,006,457	13,591,679	414,778	22,792
WHPP-Oshk	N/A	N/A	N/A	2,842,340	3,220,401	(378,061)	4,335
WHPP-WisRap	N/A	N/A	N/A	632,581	586,566	(46,015)	1,242

Nominees for SMS offices: 1991

Nominated for president elect for 1991-1992

William J. Listwan, MD of West Bend

Dr Listwan has been a member of the SMS Board of Directors since 1984 and currently represents District 1. He has served as a member of the Physicians Alliance Commission and chair of the Medical Liability Committee, of which he is still a member. In addition, Dr Listwan also serves on the Task Force on Alternatives to Tort Reform. He is also a member of the Physicians Insurance Company of Wisconsin board of directors.

Dr Listwan was elected president of the Washington County Medical Society and served from 1976-1977. He also served as president of the Wisconsin Society of Internal Medicine from 1989 to 1990. Dr Listwan is currently a member of the WISPAC Board. He currently serves as medical director of Respiratory Therapy at St Joseph's Community Hospital and as medical director for several West Bend industries.

Dr Listwan graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) and specializes in internal medicine. Board certified, Dr Listwan served his internship at Wayne County General Hospital in Detroit and completed his residency at the Medical College of Wisconsin. ❑

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Nominated for treasurer for 1991-1992

Pauline M. Jackson, MD of La Crosse

Dr Jackson was a member of the SMS Board of Directors from 1979 to 1989. In her current position as treasurer, she is an ex-officio member of the Board. She has served on the SMS Committee on Mental Health from 1979 through 1988 and was reappointed in 1989. She was the chair from 1981-1985. She is a member of the SMS Physicians Alliance Commission. Other committees she has served on include the Committee on Child Abuse, Committee on Women Physicians, Committee on Alcoholism and Other Drug Abuse, and chair

Continued on next page

Continued from preceding page
of the Task Force on Competition and Regulation. She is also a member of the Board of the Charitable, Educational and Scientific Foundation (CESF) of the SMS. She has chaired the Finance Committee of the CESF since 1986.

Dr Jackson served as president of the LaCrosse County Medical Society in 1984 and 1985, and served as secretary of the Wisconsin Psychiatric Association, and was its president in 1987-1989. She has served on the Board of Directors of the Gundersen Clinic and as chief of staff at Lutheran Hospital in LaCrosse.

Dr Jackson graduated from Stanford University Medical School and served her internship at Charles T. Miller Hospital in St Paul. Board certified in psychiatry, she completed her residency at the Cleveland Psychiatric Institute.❑

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Nominated for speaker of the House of Delegates for 1991-1993

Richard G. Roberts, MD, JD of Madison

Dr Roberts was first elected speaker of the House in 1987 and has served two consecutive terms. He currently serves as vice chair of the SMS Medical Liability Committee and a member of the Task Force on Alternatives to the Tort System. He also serves on the Executive Committee and the Board of Directors.

Dr Roberts is an associate professor and director of the Outreach and Development Division in the Department of Family Medicine and Practice at the University of Wisconsin Medical School. He is also medical director for the Belleville Clinic in Belleville. Dr Roberts is active in the American Academy of Family Physicians and serves on its Commission on Legislation and Governmental Affairs. He is a past president of the Wisconsin Academy of Family Physicians. In addition, Dr Roberts serves as an SMS representative to the Board of Governors of the Patients Compensation Fund and the Wisconsin Health Care Liability Insurance Plan.

Dr Roberts received his medical degree from the George Washington School of Medicine in Washington, DC. He also holds a law degree from the University of Wisconsin Law School.❑

Nominated for AMA Delegate 1992 and 1993

Timothy T. Flaherty, MD of Neenah

Dr Flaherty was president of the SMS from 1984 to 1985 and a member of the SMS Board of Directors from 1977 to 1983. He is currently the chair of WISPAC Board, the political action arm of the SMS, and has been a member of the AMPAC Board since 1987. Dr Flaherty has been a member of the SMS Executive Committee, the SMS Task Force on Medical Care, the SMS House of Delegates Reference Committee on Physician-owned Liability Insurance Co, and the Commission on Health Planning. He is a member of the Physicians Insurance Company of Wisconsin board of directors.

In addition, Dr Flaherty served as an alternate delegate to the SMS from Winnebago County from 1970 to 1972 and as delegate from 1973 to 1977. Dr

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Flaherty served as a SMS alternate delegate to the AMA in June 1984 and as delegate from December 1984 to January 1985 and 1990 to 1991.

Dr Flaherty received his medical degree from the Marquette University School of Medicine (now the Medical College of Wisconsin) in 1959. He served a rotating internship at St Mary's Hospital in Milwaukee and then joined the US Air Force for 3 years before beginning a radiology internship at the University of Wisconsin Hospitals in 1963.❑

Nominated for AMA Delegate 1992 and 1993

John D. Riesch, MD of Menomonee Falls

Dr Riesch was a SMS alternate delegate to the AMA from 1979 to 1987 and served as delegate since 1988. He has been a member of the SMS Commission on Mediation and Peer Review and the House of Delegates Nominating Committee.

Dr Riesch served as president of the Waukesha County Medical Society in 1973 to 1974. He is a member of the American College of Surgeons, Milwaukee Academy of Surgeons, and the Wisconsin Surgical Society.

Dr Riesch graduated from the University of Wisconsin Medical School and is assistant clinical professor of surgery at the Medical College of Wisconsin.❑

Nominated for AMA Alternate Delegate for 1992 and 1993

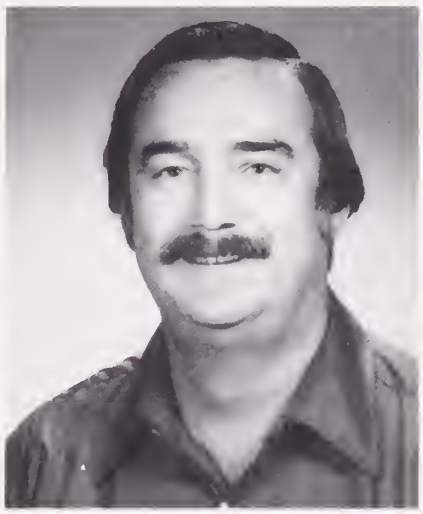
J D Kabler, MD of Madison

Dr Kabler is a past president of the SMS having served from 1988 to 1989. He is also past president of the Dane County Medical Society serving from 1978 to 1979. In addition, Dr Kabler served as a delegate to the SMS House of Delegates from District II.

Dr Kabler served on the SMS Board of Directors from 1979 to 1990. He has served as an alternate delegate to the AMA since 1981. He was also the past chair of the SMS Joint Practice Committee and the SMS Governmental Affairs Commission.

Dr Kabler has been a member of the University of Wisconsin School of Medicine faculty since 1957. He was president of the medical staff at the University Hospitals from 1979 to 1982. He is currently the director of the University Health Service, attending physician at the University Hospitals and consultant physician to the Veteran's Administration Hospital.

Dr Kabler received his medical degree from the University of Kansas. He served an internship, residency and fellowship in internal medicine at the University of Wisconsin Hospitals and Clinics.❑



Nominated for AMA Delegate 1992 and 1993

Richard W. Edwards, MD of Richland Center

Dr Edwards has served as SMS delegate to the AMA since 1984 and is currently vice chair of the delegation. He was also an alternate delegate from 1979 to 1983. Dr Edwards is chair of the Physicians Insurance Company of Wisconsin board of directors.

Dr Edwards served as councilor of the State Medical Society from District II from 1969-1978 and was also vice chair of the SMS Council from 1976 to 1978. He served as SMS treasurer from 1979 to 1981. From 1972 to 1978, Dr Edwards served as chair of the SMS Finance Committee. In 1969, Dr Edwards was appointed a member of the Governor's Special Task

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Force for Health Manpower. From 1976 through 1977, Dr Edwards was a member of the Governor's Committee to Survey Health Facilities in the state prison system.

Dr Edwards was a member of the SMS's Commission on Mediation and Peer Review from 1969 to 1985. He was elected Physician of the Year in 1982 by the Wisconsin Academy of Family Physicians.

Dr Edwards received his medical degree from the University of Wisconsin Medical School and served a rotating internship at St Vincent's Hospital in Toledo, Ohio. Dr Edwards served in the US Navy from 1950 to 1954 and began a family practice in Richland Center in 1961. Dr Edwards is Board Certified in Family Practice.❑

State Medical Society
Annual Meeting
Milwaukee
April 18-20, 1991

Nominated for AMA Alternate Delegate for 1992 and 1993

Kenneth M. Viste, Jr, MD of Oshkosh

Dr Viste is a past president of the SMS having served from 1987 to 1988. He was a member of the SMS Board of Directors from 1982 to 1989. In addition, he has served on many SMS committees and commissions including chair of the Physicians Alliance Commission from 1978 to 1985, chair of WISPAC from 1978 to 1980, and the SMS Nominating Committee from 1978 to 1985. He has also been a director for the Physicians Insurance Company of Wisconsin. Dr Viste has been an alternate delegate to the AMA since 1982. He also serves on the AMA Council on Legislation.

Dr Viste is a fellow of the American Academy of Neurology and is currently the Legislative Affairs chair of the American Academy of Neurology.

A graduate of Northwestern University Medical School, Dr Viste completed his residency and fellowship training in neurology at the Northwestern University Medical School in Chicago. Dr Viste has been an instructor in neurology at the Winnebago Mental Health Institute and is an associate clinical professor of neurology at the University of Wisconsin Medical School.❑

Nominated for AMA Alternate Delegate for 1992 and 1993

Richard H. Ulmer, MD of Marshfield

Dr Ulmer was elected to the SMS Board of Directors in 1985 and served as vice chair from 1987 to 1989. He then served as chair from 1989 to present. He was a member of the House of Delegates Nominating Committee from 1978 to 1980 and has served as an alternate delegate to the AMA since 1983. He was a member of the Steering Committee of the AMA National Forum for Employed Physicians from 1985 to 1988 and is now a member of the AMA Group Practice Work Study Group serving from 1989 to present.

Dr Ulmer received his medical degree from Stritch School of Medicine of Loyola University in Chicago. Board certified in internal medicine, Dr Ulmer specializes in internal medicine and cardiovascular diseases.❑

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Physician briefs

Charles Hammond, MD,* of Neenah, has been elected chair of the Wisconsin section of the American College of Obstetricians and Gynecologists. He will serve a 3 year term. Dr Hammond received his medical degree from the University of Illinois College of Medicine. Currently, he practices obstetrics and gynecology in Neenah and is affiliated with Theda Clark Regional Medical Center and Mercy Medical Center.

Gary Steele, MD,* of Brownsville, will be seeing patients at the Fond du Lac Clinic in Mayville in the absence of **Michael Bachhuber, MD,*** who was called to active duty in Saudi Arabia. A family practitioner, Dr Steele will be in the Mayville office Monday through Friday, from 2 to 6 pm.

Robert A. Gruesen, MD,* recently joined the Family Medical Clinic in Amery. A general surgeon, Dr Gruesen graduated from Creighton University School of Medicine in Omaha. He recently completed a 4-year residency in general surgery at the Marshfield Clinic and St Joseph's Hospital in Marshfield.

William Merkow, MD,* of Waukesha, recently joined the staff of Quad/Med, the medical clinic for Quad/Graphics employees, as associate medical director. Dr Merkow will be instrumental in setting up the facility to handle minor surgery. Dr Merkow graduated from the University of Wisconsin-Madison Medical School in 1943.

Gary Bailey, MD, of Minocqua, recently joined the Marshfield Clinic. A urologist, Dr Bailey earned his medical degree from West University and will practice at the Clinic's Lakeland Center.

Purushotham Veluvolu, MD,* of Marshfield, recently joined the Marshfield Clinic. A nuclear medicine specialist, Dr Veluvolu recently completed his fellowship in nuclear medicine at the Medical College of Wisconsin. Dr Veluvolu is a graduate of Guntur Medical College, Andhra University, India.

Robert Noyce, MD,* of Eau Claire, recently joined the staff of Sacred Heart Hospital in Eau Claire. A graduate of the University of California at San Francisco, Dr Noyce served his residency and internship at Michigan State University Affiliated Hospital. Dr Noyce practices internal medicine.

Stephen Rogers, MD,* of Eau Claire, recently joined the staff at Sacred Heart Hospital in Eau Claire. Specializing in internal medicine, Dr Rogers graduated from Creighton University in Omaha.

Stephanie Litrell, MD, of Phillips, recently opened the Ridgewood Clinic sponsored by the Flambeau Medical Center. Dr Litrell received her medical degree from the University of Kansas in Kansas City. A family practice specialist, Dr Litrell is certified by the American Board of Family Practice. ❑

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County society news

Dane. John C. Michael, MD, Madison, recently was accepted to membership in the Dane County Medical Society.

Green. Rafael Solis, MD, Monroe, recently was accepted to membership in the Green County Medical Society.

Milwaukee. Sanford R. Mallin, MD, a Milwaukee internist, was installed as the 144th president of the Medical Society of Milwaukee County during the organization's annual meeting in December. Dr Mallin addressed the meeting and focused his remarks on the problems of Milwaukee's inner city: the uninsured, teen pregnancy, alcohol and other drug abuse, and urban violence. The society bestowed its highest honored on DeLore Williams, MD, of West Allis, with a Distinguished Service Award. The award recognizes a lifetime of exemplary services to the profession and community.

The following physicians have been accepted to membership in the Medical Society of Milwaukee County. They are MDs Tina M. Joannides, Wauwatosa; Jennifer N. Klopfstein, Fox Point; and Debra L. Schaeffer, of Wauwatosa.

Oneida-Vilas. Twenty-five members were present at the November meeting of the Oneida-Vilas County Medical Society to hear Kenneth M. Viste, MD, past president of SMS, speak on the benefits of being an AMA member. Kenneth A. Miller, MD, Rhinelander, was accepted to membership.

Rusk. At the November meeting of the Rusk County Medical Society, a field representative of the SMS Division of Public Affairs, was present to advise the members that the Board of Aging and Long-term Care would be surveying Wisconsin physicians to determine whether or not they accepted Partner Care. Election of officers for 1991 are the following MDs:

Sanford Mallin, MD, is the new president of the Medical Society of Milwaukee County.

Rebecca Allen, president; Ron Charipar, secretary, and Douglas DeLong, delegate to the SMS.❑

Obituaries

Richard D. Brown, MD, 68, of Eau Claire, died Oct 11, 1990, in Eau Claire. Dr Brown was born Sept 11, 1922, in Stone Lake, and graduated from the University of Pennsylvania School of Medicine. He served his internship at Philadelphia General Hospital, and he completed his obstetrics/gynecology residency at Milwaukee County Hospital. Dr Brown Served in the US Army from 1943-1946, and the US Navy from 1954-1956. He had been a member of the SMS Commission on Scientific Medicine and a member of the SMS Committee on Maternal Mortality. He had been a member of the Midelfort Clinic from 1953 until his retirement in 1987. He was a past president of the Wisconsin Society of Obstetrics and Gynecology. Dr Brown also had been a member of the board of directors of Luther Hospital in Eau Claire. He was a member of the Eau Claire-Dunn-Pepin County Medical Society, the SMS, and the AMA. Surviving are his widow, Lillian; a son, William, and a daughter, Anne.

Earl F. Cummings, MD, 86, of Oshkosh, died Oct 23, 1990, in Oshkosh. Dr Cummings was born Feb 1, 1904, in Clarion, Iowa, and graduated from the University of Wisconsin Medical School, Madison. His internship was served at Madison General Hospital (now Meriter), and his residency completed at the University of Wisconsin Hospital and Clinics in Madison. Dr Cummings served in the US Army Medical Corps during World War II. He is a past president of the medical staff at Mercy Hospital, Oshkosh. He was a member of the Wisconsin Urological Society, and a member and past secretary of the Winnebago County Medical Society, and a member of the SMS, and the AMA. Surviving are his widow,

Burdean; two daughters, Jane Wyman, of San Jose, Calif, and June Ochowicz, of Oshkosh.

Frederick I. Bush, MD, 74, of West Bend, died Oct 28, 1990, in West Bend. He was born Feb 18, 1916, in Fond du Lac, and graduated from Marquette University School of Medicine in 1943. Dr Bush completed his internship and residency at St Joseph's Hospital in Milwaukee. He served as a surgeon with the US Army during World War II. Dr Bush maintained his medical practice in West Bend from 1946-1977. He also was on the medical staff at the Samaritan Home in West Bend until his retirement in 1990. Surviving are his daughter, Christine and her husband, Bruce Schulthess, of Milwaukee, and three grandchildren.

Nels Alfred Hill, MD, 89, formerly of Madison, died Dec 15, 1990, in St Petersburg, Fla. He was born Nov 22, 1901, in Hamilton County, Iowa, and graduated from Harvard Medical School. His internship was completed at University Hospitals, Madison, and his residency at the Lahey Clinic in Boston, Mass. Dr Hill practiced medicine in Madison for forty years retiring in 1972. He served on the medical staffs of Meriter Hospitals (formerly Madison General and Methodist), and St Mary's. He was chief of staff for four years at Madison General. Dr Hill was an instructor and a preceptor at the University of Wisconsin Medical School and also taught in the nursing schools at both St Mary's and Madison General hospitals. He was past president of the Dane County Medical Society and the State Medical Society of Wisconsin, and also a delegate to the AMA. Dr Hill served on the board of directors of SMS from 1953-1962. He served on the board of trustees of the Interstate Postgraduate Medical Association from 1960-1977, and was medical director for the Wisconsin Life Insurance Company. He served as local surgeon for the Illinois Central Railroad, and physician for the Civilian Conservation Corps. He was a member of the American Heart Association, the Wisconsin Society of Internal Medicine, the American Geriatrics Society, the Retired Physicians Association, Dane County Medical Society, the SMS, and the AMA. He was preceded in death by his wife, Dr Agnes Z. Hill in 1982.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑

Edward Ralph McNair, MD, 93, of Orfordville, died Dec 3, 1990, in Evansville. Dr McNair was born Sept 29, 1897, in Brodhead, and graduated from Rush Medical College in Chicago. His internship was completed at Blodgett Memorial Hospital in Grand Rapids, Mich. He had been a member of the United States Army during World War I. Dr McNair practiced in Michigan for a short time and then opened his office in Orfordville in 1933 and practiced medicine until his retirement in 1980. He served as village health officer for many years and was the Orfordville school examining physician. He was a member of the Rock County Medical Society, the SMS, and the AMA. He was preceded in death by his wife, Margaret.

Raymond J. Rogers, MD, 84, of Lake Park, Fla, died Nov 1, 1990, in West Palm Beach, Fla. Dr Rogers was born Sept 20, 1906, in Oconto. He graduated from Marquette University School of Medicine and served his internship at Milwaukee County General Hospitals. His pathology residency was completed at the Hines Veterans Administration Hospital in Maywood, Ill. Dr Rogers served in the United States Army Medical Corps during World War II. After service he became affiliated with the Kellogg Foundation to upgrade and improve the work in pathology departments in Wisconsin and Upper Michigan hospitals. He was a member of the Marinette-Florence County Medical Society, the SMS, and the AMA. Surviving are his widow, Mabel; one daughter, Sylvia Koscielski, of Madison; two sons, Dr John R., of Fairfax, Va, and Erwin J., of Tallahassee, Fla

Irvin Lewis Schroeder, MD, 72, of Plymouth, died Oct 30, 1990, in Piedmont, Calif. Dr Schroeder was born Sept 24, 1918, in Clintonville, and graduated from Marquette University School of Medicine. His internship was completed at Milwaukee Passavant Hospital. Dr Schroeder served in the United States Army from 1945-1947. From 1951 until 1977 he practiced medicine in Sheboygan and then moved to Plymouth where he became associated with the Valley View Medical Center in a surgical practice. Dr Schroeder had been a councilor of SMS from the sixth district from 1979-1985. He was a member of the Sheboygan County Medical Society, the SMS, and the AMA. Surviving are his widow, Loretta; two sons, Paul, of Piedmont, Calif, and the Rev. Thomas, of Kohler.❑

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Urgent Care. Seeking BC/BE MD for 36 MD multi-specialty group on Lake Michigan in southeastern Wisconsin. Prefer specialty training in FP, IM, EM, surgery. Partnership possible within 18 months. State-of-the-art facility and equipment. Competitive compensation package negotiated. Beautiful setting. Abundance of recreational cultural activities. Contact: Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. p2-4/91

Urologist. Beautiful southern Wisconsin. BC/BE urologist to join 60-member multi-specialty clinic adjacent to 250-bed hospital. Community of 55,000 with excellent lifestyle. Good benefits and salary guarantee with full partnership after one year. Send CV to: Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St., Janesville, WI 53545. p2-7/91

Madison. The Disability Determination Bureau, expects to release Requests for Proposals on Feb 15, 1991, for consulting services for the determination of disability for social security, supplemental security income, and medical assistance. Consulting specialties are in the areas of general and internal medicine, orthopedics, psychiatry, pediatrics, and neurology. The anticipated deadline for proposals is Mar 8, 1991. For details contact: James Twist, Disability Determination Bureau, Department of Health and Social Services, State of Wisconsin, PO box 7886, Madison, WI 53707-7886. 2/91

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West Bend, Wisconsin. Seeking full-time and part-time emergency physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided, benefit package, and incentive bonus plan available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p2/91

Lake Winnebago, Wisconsin area. Seeking director, full-time and part-time emergency physicians for low volume 60-bed hospital. Attractive compensation, full malpractice insurance coverage and benefit package available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 in Michigan 1-800-632-3496. p2/91

Antigo, Wisconsin. Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p2/91

Kewaunee, Wisconsin. Seeking part-time emergency physicians for low volume facility located 1/2 hour east of Green Bay. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 South Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p2/91

Medford, Wisconsin. Seeking director, full-time, and part-time emergency physicians for moderate volume facility located in northern Wisconsin. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p2/91

Chicago. Seeking full-time and part-time emergency physicians for new contract in metro Chicago area. 200-bed hospital with annual volume of 8,000. Require emergency medicine or primary care training and experience. Excellent compensation, malpractice insurance provided, benefits available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p2/91

Dermatologist, psychiatrist, allergist, internal medicine, family practice. A progressive, 126-bed, two-hospital system is seeking the above specialties to establish practices in the Iron Mountain area of Michigan's upper peninsula. Must be BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, C02 laser, and a fully-staffed special diagnostic department. Contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; ph 906-779-4500. 2-3/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Land of 1,000 Grand Lakes, seeking BC/BE orthopaedic surgeon to associate with well-established, busy orthopod in Grand Rapids, Minnesota. A highly attractive area to sports enthusiasts. One orthopaedic surgeon currently serves a service area of 65,000. Rapid practice growth assured. A competitive income and benefit package offered. For further details call, MaryAnn Riley, 1-800-638-6942. 2/91

Beautiful southern Wisconsin. Riverview Clinic, a 60-member multi-specialty clinic in Janesville, is seeking a third general surgeon. Clinic is adjacent to a modern, well-equipped hospital and has three primary care satellites in neighboring communities. Janesville, a city of 53,000, is centrally located between Madison and Milwaukee and close to Chicago. Excellent benefit package and salary guarantee first year with a full partnership thereafter. Send CV to Ronald Karzel, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 2-5/90

Emergency physician, Milwaukee. Excellent opportunity for BC/BP emergency or otherwise qualified physician to join a stable, well-established, board certified fee-for-service group staffing a 560-bed tertiary care teaching hospital's ED. 35,000 visits annually. Excellent specialty back-up. Peak double coverage on a daily basis. Salary starts at $130,000 per year for 40-hour work week, plus paid malpractice coverage and four weeks paid vacation/CME in first year. Exceptional benefits including paid vacation that grows to 12 weeks per year. Equitable partnership available. Send CV to I. Gailans, MD, FACEP 5000 W. Chambers St, Milwaukee, WI 53210; ph 414-447-2171. 1-2/91

Physicians Exchange

Continued

Family Practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes, Anderson Memorial Hospital, Main St, Norway, MI 49870; ph 906-563-9243 or office 906-563-9255. 1-2/91

Opportunity for BC/BE family physician to join well-established physician in Christ-centered family practice. Newer offices located adjacent to hospital. A 1991 FP resident graduate would be welcome. Please contact Thomas R. Jensen, MD, 8800 West Lincoln Ave, West Allis, WI 53227; ph 414-321-7373. 1-2/91

Family practice. Crystal Falls, in Central Southern Upper Peninsula of Michigan, is seeking a BE/BC family practice physician. The physician will have the option of joining an existing practice or setting up a hospital-sponsored practice. Service area of 8,000. Contact H. B. Purdy, CEO, Crystal Falls Community Hospital, Michigan Ave, & Third St, Crystal Falls, MI 49920, or phone; office 906-875-4144 or home 906-875-4145. 1-3/91

Anesthesiologist needed for a two-week medical missionary tour. To be part of an orthopaedic surgical team at Esperanca Hospital in Santarem, Brazil, from August 11-24, 1991. For information contact W. W. Schaefer, MD at 414-452-5320. 2-3/91

Family practice opportunity on the shores of beautiful Lake Michigan. The Two Rivers Clinic, Ltd., an 11-physician multi-specialty group is seeking BC/BE physician to join four family practice associates. Exceptional quality of life and outstanding recreational area for family. New facility within walking distance of hospital and nursing home. Excellent income potential. Send CV or contact Jack Gospodarek, Executive Director, 2219 Garfield Street, Two Rivers, Wisconsin collect 414-739-2281.

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Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

Lower Wisconsin River family practice or general practice, full service clinic. Over $300,000 gross. Associate wanted. Salary or partnership available. Send CV or call Muscoda Medicenter, Steven M. Liss, MD, 525 N Wisconsin Ave, Muscoda, WI 53573; ph 608-739-3192. 12/90;1-2/91

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Family practitioner BC/BE, to join a progressive 13-physician group practice in July 1991. Rural college town 30 miles from St Paul, Minnesota, with community hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701 or 612-436-8809. 3tfn/90

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April 18-20

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Medical Meetings-Continuing Medical Education

April 18-20, 1991: SMS Annual Meeting at Wyndham Hotel, MECCA, Milwaukee. g2-4/91

April 21-23, 1991: "21st Annual Meeting of the Wisconsin Association for Perinatal Care, Holiday Inn-West, Madison, WI. For more information contact Kim Hallock, WAPC Statewide Office, 1010 Mound St, Madison, WI 53715; ph 608-267-6060. 2-3/91

AMA

June 23-27, 1991: Annual AMA House of Delegates, Chicago.
December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association*.

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State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1991-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1991 - April 18-20: Milwaukee Wyndham Hotel
1992 - April 23-25: Milwaukee
1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday; the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
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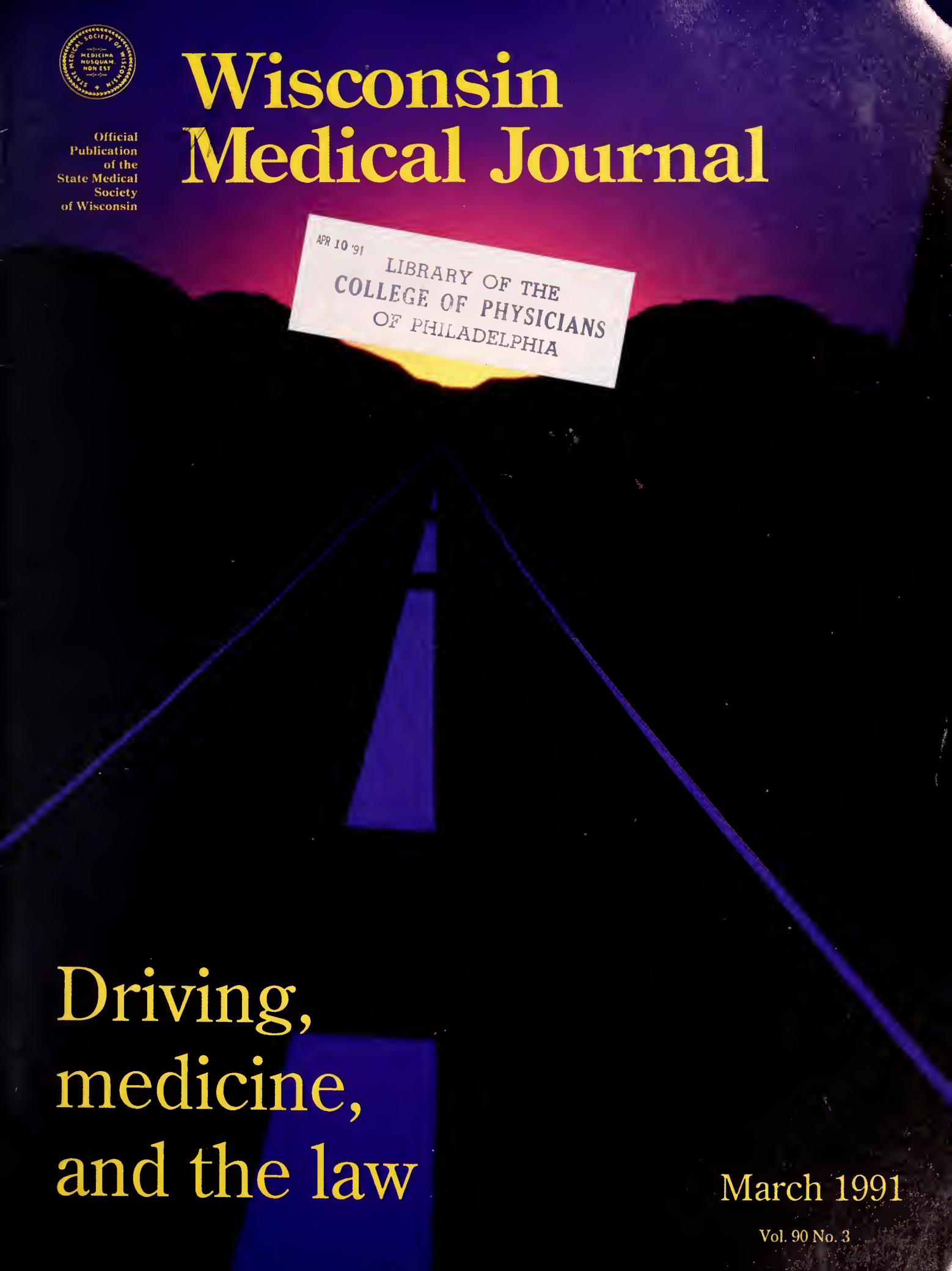

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Contents

March 1991 **Vol. 90 No. 3**

Opinions

99 *President's page*
When do we take a stand?
by Roger L. von Heimburg, MD, Green Bay
100 *Secretary's report*
Who will write the history of medicine?
by Thomas L. Adams, CAE, Madison

Editorials
102 The question of cesarean sections
by Russell F. Lewis, MD, Madison

Letters
105 Lyme disease article questioned
by Michael J. Smullen, MD, Green Bay
106 The author responds
by Michael F. Finkel, MD, Eau Claire
106 Unlimited liability protection
by Raymond Witt, MD, Kenosha

Scientific

109 Medical aspects of driver licensing in Wisconsin: An historical review
by James L. Weygandt, MD, Kohler
112 Automobile driving and epilepsy: a medical perspective
by Phiroze Hansotia, MD, Marshfield
115 Diabetes and the license to drive
by Edward N. Ehrlich, MD, Madison

Socioeconomic

119 A legislative view of driving and legal restriction
by David Helbach, Wisconsin state senator, Stevens Point
122 *Public health*
Risk factors for lung cancer: a pilot study in five counties
by Patrick Remington, MD; Henry Anderson, MD; Larry Hanrahan, MS; and Linda Haskins, Madison
126 HMO financial reports

Organizational

127 Annual meeting offers a full agenda
128 Annual meeting sessions at a glance
132 Physician briefs
132 County society news
133 Obituaries
134 CES Foundation contributors: 1990
140 Recent actions of the SMS Board of Directors

Our cover: From Comstock Stock Photography, New York.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

When do we take a stand?

WHAT CONGRESS HAS DONE in the Omnibus Budget Reconciliation Act of 1990 to payments for Medicare services borders on the irresponsible, and we physicians should not take it lightly.

Before RBRVS even has a chance to begin more equitable payments for Medicare services, Congress is gutting the system. As part of OBRA '90, Congress reduced the 1991 Medical Volume Performance Standard (MVPS) to a 3.3% increase for surgery and 8.6% for other services. Originally, the Department of Health and Human Services recommended MVPS increases of 8.7% for surgery and 10.5% for other services. After the American College of Surgeons' ill advised but successful attempt to persuade Congress to create a separate "Expenditure Target" for surgeons, the surgeons now have what they wanted and the increase they are getting is less than that of other doctors and less than the rise in the Medicare Economic Index. We surgeons will see the effect in our Medicare allowable charges in 1992. Already in 1991, with the scaling back of payments for 244 "overpriced procedures," there has been a decrease in my fees of up to 15% compared to 1990. I did not think that my procedures were overpriced. With Medicare paying only 64 cents on the dollar in 1990, how much lower will the percentage be after these further reductions? This means further cost shifting to the beleaguered non-governmental payors, which will make their cost of care problem worse. How far does this go before we take a stand?

The latest outrage has been the attempted immense cutback in payments by Congress for the administration of Medicare. HCFA wrote to all carriers to cut back on claims processing so that there would be a 60- to 70-day delay. This would mean the layoff or transfer of 80 claims processors in Wisconsin alone, and the holdback of about $80 million dollars in payments in Wisconsin.

US Rep Toby Roth (R-Green Bay) invited me to a luncheon in January and, among other things, we had a frank discussion regarding Congress' futility in dealing with Medicare. He was unaware of the holdback in

Continued on next page

Roger L. von Heimburg, MD

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Continued from preceding page
administrative funds and promised to look into it. There is a contingency fund in OMB of $131 million which could be tapped for this, but Richard Darman, the director, refused to release the funds initially. On the last day of January he was persuaded to release $75 million, so this staves off the problem until August 1991 or so, but does not solve it.

In my discussion with Congressman Roth, I told him that it appeared to me that Congress had the perception that doctors, being humanitarian, would just accept any cuts Congress wanted to make in Medicare and would continue to serve the system, and I asked him if that were true. He dodged the question. I told him that we have about reached the point where a significant number of doctors may just drop out of the program. I told him that Congress was reneging on its promise made to the American people in the Medicare law to provide medical care for those age 65 and older.

OBRA '90 extracted $43 billion in Medicare cuts between 1991 and 1995. Before these cutbacks have had any chance to begin to play out, President Bush, in his 1992 budget, called for an additional $25 billion in Medicare cuts over 5 years. Although Medicare makes up only 11% of the federal budget, it is being hammered with 21% of the cuts in the budget. This is not reasonable or fair to the elderly.

What can we do about this? We have the answer walking into our offices everyday–our patients. We should take an extra 2 minutes with each elderly patient to explain the unconscionable underfunding of the Medicare system and ask them to write or call their representatives, senators and president to correct this serious problem. A groundswell of acknowledgement of the problem is bound to help. Today is the time to start.❑

Secretary's report
Who will write the history of medicine?

"IT IS BETTER to be making the news than taking it," wrote Winston Churchill, "to be an actor rather than a critic." I think of that remark almost every time I pick up a newspaper.

On the East Coast, Sen Edward Kennedy is promoting a bill that would require all employers to provide a basic health insurance benefits plan to full-time employees and their dependents, as well as create a public insurance plan for those not covered by employer-provided plans. The plan would set up a regional network of insurance carriers that would be required to offer small employers enrollment in managed care systems.

On the West Coast, Rep Pete Stark is stumping for a national health insurance and long term care package that he calls "Mediplan." It would provide basic health and long term coverage to all Americans through employer insurance or a public plan similar to Medicare. The $120 billion cost of this Mediplan would be covered by a new 4% federal tax on incomes above $16,000 per year, all Social Security benefits, and gross corporate income.

In Florida, AFL-CIO President Lane Kirkland came out in favor of national health insurance legislation and trying to form a coalition to make health care reform a major issue in the 1992 presidential election. The plan Kirkland is currently supporting is known as "play or pay." It would require companies to either provide minimum health care coverage for employees or pay a tax into a government-run fund that would provide medical coverage for their workers.

In Washington, Representatives Henry Waxman and Richard Gephardt, Senators Lloyd Bentsen and Jim Jeffords, the OMB's Richard Darman, HHS Secretary Louis Sullivan, even President Bush are all working to be actors, and to play major roles, in health care system reform. Unfortunately, most of the rhetoric so far has concerned itself with one

Thomas L. Adams, CAE

version or another of a single-payer (ie, the federal government) system.

What's encouraging is that the nation is watching. Some are motivated by the plight of America's 37 million uninsured (24 million of whom are working), and some by the costs

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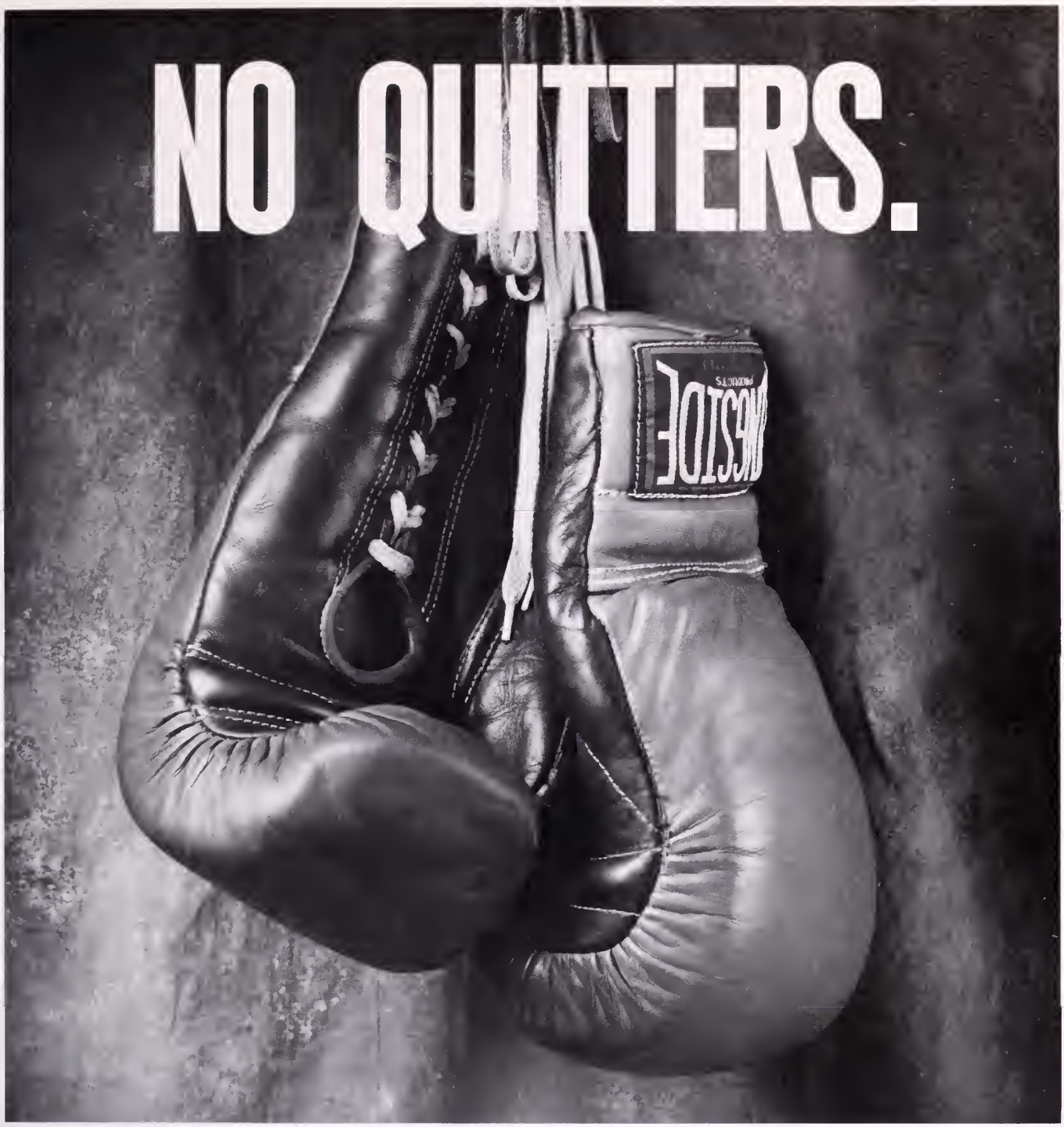

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Continued from page 100
of providing health care. But two things are certain: health care *will* be a major issue in upcoming elections, and changes in the ways the nation pays for its health care *will* be coming.

The good news is, however, that that is about all that is certain.

In Wisconsin, the SMS has negotiated a series of system reforms–with the Wisconsin Manufacturers and Commerce, the Wisconsin Hospital Association, the health insurers coalition, and others–that propose changes ranging from fully funding Medicaid to public participation in hospital capital expansion projects. This proactive stance by the Society is a first step that ensures the profession's ability to be at the table for the Wisconsin version of the national debate.

Our first steps here in Wisconsin demonstrate that you and your fellow physicians still have the opportunity to make the news rather than take it, to shape the future of medicine rather than have it imposed on you.

Physicians have traditionally been reluctant to assume leadership roles in health care debates, partly because the gritty business of politics is not something they relish and partly because they did not want to appear to be a self-serving special interest group. Such reluctance, however, is no longer either appropriate or responsible.

Yes, the standard of living could be affected by the coming changes in health care. Yes, the nature of your daily work could be affected. And yes, the health and strength of your profession could be affected. But more importantly, the health of your patients could be adversely affected by the changes that emerge from the coming debates. It is to their welfare that you are dedicated as professionals, so your participation–your leadership–in the health care reform debates becomes part of your professional responsibility.

Leadership, however, requires both an open mind and a measure of creativity. There can be no proverbial lines drawn in the sand; there can be no digging in of the heels and rigid refusal to entertain new ideas. AFL-CIO President Kirkland described his organization's strategy on health care reform thusly: "We are not committed to any rigid single plan. We are in a negotiating posture and we intend to approach it in a practical way...." Organized medicine will do well to adopt the same posture. ❑

Editorial
The question of cesarean sections

In late July the *Chicago Tribune* had a most provocative editorial on the subject of cesarean section. It proposed that in today's environment, with the emphasis on informed patients, women early in their prenatal care be given the option of a section or a vaginal delivery. It was pointed out that the difference in maternal mortality associated with section was probably not significant–40 women out of 100,000 dying after section compared to 10 out of 100,000 with vaginal deliveries. The rationale for this conclusion was that most of the deaths related to section were caused by the indication for the surgery rather than the result of it.

After more than 40 years experience in obstetrics at Marshfield, I would not only like to endorse this suggestion but agree with the rationale. Because of the current malpractice situation it seems to me that the section rate might even go up further to the benefit of all.

Let me illustrate my feelings by describing a case that occurred the first weekend I was on call in 1946. A primigravida age 42 came almost ready to deliver but she and her husband demanded an immediate section because her regular doctor had told her that because of her age it was vital to her welfare and that of the baby that she have a section. It was done and all was well.

Monday morning I complained to my mentor Dr James Vedder Sr. He remarked "Russ, you have been taught the usual indications for section, but what rarely appears in the books may be just as important. Always do a section when dealing with a valuable baby." He pointed out that, of course, all babies are valuable but in a few situations some babies are extra valuable. To explain he defined three categories:

1. Babies being born to primigravidas over the age of 40.
2. Babies being born to couples with an infertility problem of more than 10 years.

For both of these groups the reason being that the chance of a future successful pregnancy is small.

3. Babies being born to someone prominent in the community with an otherwise borderline indication for a section.

His basic philosophy for all three

Continued on page 105

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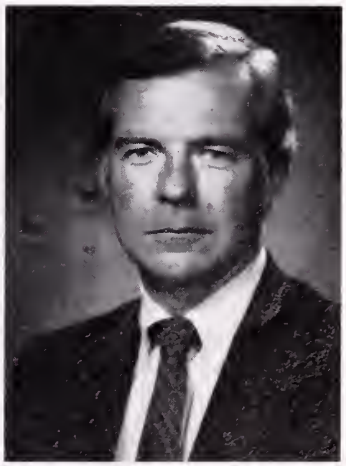

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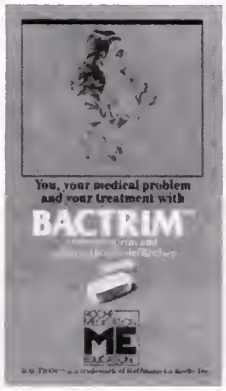

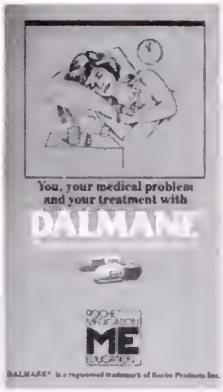

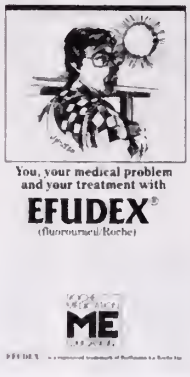

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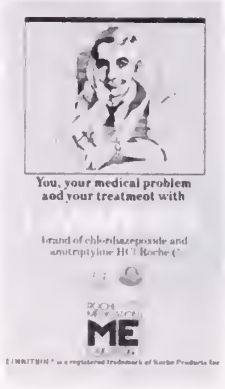

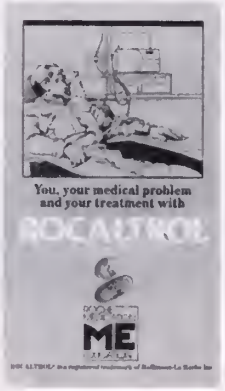

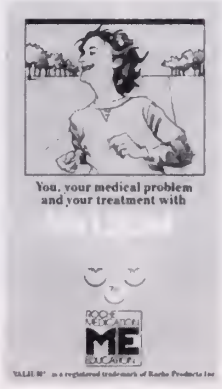

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groups was "if you do a section and something untoward happens to the mother or the baby, no one will blame you since you have done everything possible. On the other hand, if you do not do the section and there is an unfortunate outcome, everyone is going to feel you made a mistake in not doing the section."

Back in Dr Vedder's day, and for most of my career, if a baby were lost or not normal, the parents and the community believed "it was God's will." Today they feel, or someone convinces them, that the doctor must have been at fault. This also conveniently relieves the patient of any responsibility, plus giving the chance to become rich.

Obstetricians have learned most of the lesson well, with the result being the 25% section rate nationally. Many still need to learn that at the first sign of trouble in a baby being monitored, ***do this section***. Several lawsuits have been lost in recent years by excellent obstetricians who elected to watch closely and wait only to section later, have a bad baby and lose the suit when some expert comes in and testifies that the section should have been done sooner.

Recently, under the guise of cost containment, there has been a move to lower the section rate. Cost should never be a factor. It is true that sections will always require more hospital days and so more expense. However, to partially compensate for that physician reimbursement should be drastically altered. Certainly, a relatively simple surgical procedure often done at 8 am taking about 45 minutes should be rewarded at a much lower rate than supervising a woman through 4 to 12 hours of labor, often missing the office or sleep for a vaginal birth either normal or difficult. Now would seem a good time to reimburse the doctor for what is usually much more time consuming and difficult, plus the much lower danger of a malpractice suit for the section.

Even if the malpractice problem were solved tomorrow, it seems to me at the first prenatal visit the patient should be told the pros and cons of both types of delivery and given a choice. If the patient elects section, make sure the baby is mature and do it electively. If she choses vaginal delivery, tell her she has the option at any time to change her mind. Also explain that at any moment there may be a question as to the safety of the baby, a section will be performed. Having accomplished this, document everything well and go back to enjoying the most happy and satisfying of all the medical professions.

—Russell F. Lewis, MD
Madison ❑

Letters
Lyme disease article questioned

TO THE EDITOR: I am writing regarding an article that appeared in a recent issue of this journal, Finkel M, Johnson RC: Borrelia lymphocytoma: a possible North American case, *Wisconsin Medical Journal* 1990;89 (12): 683-686. In this article, the authors write a speculative article regarding a rare dermatologic disorder that occurred within Wisconsin in the past year.

I was surprised to see that such a poorly documented case would be published in the *Wisconsin Medical Journal*. Certainly this article, as written, would have been extremely unlikely to have been published in any refereed medical journal. Dr Finkel and his colleague have very limited circumstantial documentation of this skin disorder having been made. The basis for this skin disorder requires scientific documentation by a minimum of a skin biopsy, clinical photograph, or a culture of the spirochete or organism to substantiate a rare or initial case.

I would propose that the publishing of such articles in the *Wisconsin Medical Journal* will certainly reduce the scientific value to all physicians and perpetrate mediocrity. This article, unfortunately, will be reviewed by others only to come to the same conclusions and will categorize the journals as poorly conceived.

In the future, any published article should have critical peer review by others in the medical community. I can't imagine how a specialist in one field, a neurologist in this case, could not have benefited by having a dermatological panel evaluate an article about dermatology. We have too many "possible" cases entering our practices on a daily basis.

Please, let us substantiate our claims.

— Michael J. Smullen, MD
president, Wisconsin
Dermatological Society❑

EDITOR'S NOTE: The preceding letter was written by Dr Smullen and is self-explanatory. Although described as

Continued on next page

Continued from preceding page
ad hominem and acerbic by a member of the editorial board, I believe it is worthy of comment.

Two of the eight members of the Editorial Board did not favor publication because the diagnosis was not proven by biopsy. However, the title did offer a disclaimer–"Borrelia lymphocytoma: a possible North American case."

Having spent time with Dr Willy Burgdorfer, I would like to inform Dr Smullen that it is extremely difficult to find a spirochete in the biopsy of a patient with known lyme disease. A negative biopsy does not rule out the diagnosis. Culture of this organism, in anything but a very sophisticated research laboratory is impossible.

Dr Burgdorfer has stated for the diagnosis to be helpful to the patient, it is either established by the presence of a pathognomonic skin lesion or the history of such a skin manifestation together with a positive serology. Both were present in this case report. There is a more sophisticated and specific test using a polymerase chain reaction, but this is not widely available. I did not ask Dr Burgdorfer to review this paper, but I strongly suspect he would have supported the diagnosis, because the pathognomonic skin lesion was present on examination.

It is true that I did not consider having this manuscript reviewed by a dermatologist, as in my limited experiences patients with lyme disease are more often treated by other disciplines.

Dr Smullen is grossly mistaken regarding the peer review of manuscripts that appear in the *Wisconsin Medical Journal.* Of the manuscripts submitted for consideration by the *WMJ* Editorial Board, an average of 26% are accepted for publication, 35% are rejected outright, and 39% are returned to the authors for revision and resubmission.

Disciplines represented on the editorial board are as follows: radiology, pathology, pediatrics, internal medicine, family practice, general and vascular surgery, cardiology, thoracic and cardiac surgery. There will be a position open on the board this year, I would encourage Dr Smullen or any other physician who has an interest to become candidates.

Finally, I will gladly accept responsibility for the publication of this manuscript. Even if I would have had Dr Smullen's comments at hand while the review process was taking place I would have followed the same course. I have also asked the author of the manuscript to reply to Dr Smullen's comments. Those comments can be found below.

–Richard D. Sautter, MD
medical editor ❑

The author responds

TO THE EDITOR: I am writing to respond to the letter of Michael J. Smullen, MD, regarding my case report in the December 1990 *Wisconsin Medical Journal.*

This case report describes a woman referred to me by a family practitioner who took photographs of her multiple skin lesions and who started her on antibiotics before she saw me. There were problems extricating the film from the camera, and several shots were lost. I have pale, unsuitable for publication, photographs of several erythema migrans lesions on this patient. Unfortunately, there were no pictures of the breast lesion.

I did not recognize the significance of her breast lesion until she had been on therapy for approximately two weeks, at which point the lesion of the breast had subsided. However, having seen Dr Åsbrink's photographs and read her article, there is no question in my mind that the very specific breast lesion was a Borrelia

Continued on page 108

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Continued from page 106
lymphocytoma, accompanied as it was by multiple erythema migrans lesions and irrefutable immunologic evidence.

When one reviews the recent articles in which Borrelia lymphocytoma is described, one finds that there are no color photographs published in the past 5 years of any of the reported cases. Dr Eva Åsbrink relates that no one has been able to culture the spirochete from any of the biopsied lesions. It is also extremely difficult to demonstrate the spirochetes in pathologic specimens. The only pathologist who has been able to find the organisms with consistent success is Dr Paul Duray, as a review of the pathology literature will demonstrate.

When the article was submitted, we realized that it would be subject to criticism because there are no photographs. Therefore, the article was specifically titled, "a **possible** North American case." We believed it merited publication without the photographs, as it is important for Wisconsin physicians to be aware of this unusual skin disorder so they can refer these cases to dermatologists for photography and biopsy. Since most of Wisconsin's dermatologists do not live in the part of the state where the disorder occurs, the patients will first be seen by the primary care physician. These physicians need to know that this disorder exists.

The first report of erythema migrans in North America was made by Dr Rudy Scrimenti, a Milwaukee dermatologist. As we all know now, Lyme borreliosis was present at the same time in Wisconsin as it was in Connecticut; the Connecticut physicians were fortunate to be able to put everything together before those of us in Wisconsin could. Wisconsin physicians still can play a role in elucidating the different presentations of this infection.

Finally, I would like to remind Dr Smullen that many important medical specialty syndromes have been described by people in primary care or in other specialties. My own field of neurology has the examples of both Dr Huntington and Dr Parkinson who wrote thorough detailed descriptions of their patients that can be used by physicians today to recognize individuals with the same disorders. I shudder to think what would happen in 1991 if these general practitioners tried to submit those papers without a videotape to substantiate their observations!

— Michael F. Finkel, MD
medical director
Western Wisconsin Lyme Disease Center❑

Unlimited liability protection

TO THE EDITOR: In reference to the letter of Dr Albert L. Fisher in the December issue of the *Wisconsin Medical Journal,* I agree completely with his premise that Wisconsin physicians should not be forced to purchase unlimited liability protection. You state that the physician membership of the SMS "voted" to support the PCF. When was such a vote taken? Does the present membership continue to support a system, which no other state in the Union has seen fit to duplicate?

–Raymond Witt, MD
Kenosha

EDITOR'S NOTE: A special session of the 1975 SMS House of Delegates voted unanimously to support a bill creating the PCF. The SMS participated in the drafting of the bill, and more than 300 physicians testified on its behalf at a public hearing. In 1988, a resolution calling for the SMS to work for repeal of mandatory unlimited professional liability insurance was rejected by the House of Delegates.❑

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Medical aspects of driver licensing in Wisconsin: an historical review

James L. Weygandt, MD, Kohler

Attendant with the growth in numbers of automobiles during the past century has been the growth in crashes, some of which are caused by medical conditions which affect the driver. This article summarizes briefly the legislative and medical profession efforts to assure that healthy operators control these machines. *Wis Med J* 1991;90(3):109-111.

THE FIRST OPERATOR LICENSES were issued in Indiana in 1896. This was at a time when there were fewer than 100 automobiles– electric, steam, and gasoline combined–in all of the United States, though within the next two decades there was a tremendous increase in their numbers, from an estimated 8,000 in 1900 to more than 2.3 million in 1915.

The first automobile fatality in this country occurred in New York City in 1899. These numbers, too, increased so that by 1906 a *Journal of the American Medical Association* editorial urged: "The numerous accidents from motor cars call for special legal requirements as to those who handle them–his special senses and general physical condition should be required to be in as good a state as those of the locomotive engineer. If an automobilist is out of health, nervously weak, defective in sight and hearing, or under the influence of drugs or stimulants, he is not a safe man to run an automobile...."[1]

In 1923, the AMA created the Committee on Physical Standards for Drivers of Motor Vehicles which reported at the June 1924 meeting: "We, as a profession, should insist on the passage of laws in each state with a view to restricting the granting of licenses to operate motor vehicles to such persons as may submit themselves to physical tests at the hands of properly qualified medical and surgical practitioners and have demonstrated their physical fitness. As the opinions of practitioners regarding such physical ability may vary, it is necessary that a standard be adopted of a minimum amount of efficiency below which it would, in the majority of instances, be unsafe for applicants to operate such vehicles."[2]

Recommendations from the committee included:

- no disqualifying defects of legs or arms (anatomic or functional loss of hand, arm, foot, or leg);
- vision of at least 20/50 in one eye and at least 20/100 in the other, with or without glasses;
- double vision shall disqualify;
- must be able to hear a low spoken voice at 5 feet; and
- the mentality of the applicant must be adequate and the heart's action reasonably healthy.

This report was adopted by the AMA House of Delegates, but implementation was slow and by 1929 only ten states and the District of Columbia had mandatory examinations for drivers' operators licenses.

Wisconsin

In 1927 Wisconsin enacted a driver licensing law, effective in 1928. The law provided for lifetime licensure with no fee for auto owners and a 25 cent fee for "others." The law specified those who would not to be permitted to drive (s. 85.08): "Who may drive auto; ... No person under the age of sixteen years unless accompanied by an adult and no intoxicated person or person subject to epilepsy shall operate any automobile, motor truck, motor delivery wagon, automobile bus, motor cycle or other similar motor vehicle on any highway."

A Wisconsin legislative committee reported in 1931 that "the Drivers

Dr Weygandt is with the Kohler Company Medical Department. He has received the SMS Meritorious Service Award for his 31 years of service (24 years as chair) on the SMS Committee on Safe Transportation. Reprint requests to: James L. Weygandt, MD, Kohler Company, Medical Department, Kohler, WI 53044. Copyright 1991 by the State Medical Society of Wisconsin.

License Law was enacted in the 1927 session of the Legislature after many years of effort on the part of citizens and organizations interested in safety. This law, however, does not contain the important features of examination, accident reporting, and periodical renewal as a large number of states embrace in their respective statutes.

"The present Wisconsin Drivers License Law, which was admittedly weak at the time it was enacted, was primarily aimed at the drunken driver ... As there are many other causes for revoking licenses, in addition to intoxication, the committee recommends that the law be strengthened to cover a wider range of causes for revocation."

The law was broadened in 1931[3] and restated in 1941, (s. 16): "Persons not Qualified for Licenses: no driver's license shall be issued to the following: (a) any person under sixteen years of age, except as provided in subsection (1a) of s. 85.08; (b) any person physically or mentally incompetent to safely operate a motor vehicle; (c) any person whose driver's license or motor vehicle license has been withheld, suspended or revoked in Wisconsin or in any other state or country, during the period for which such restrictions are in force; (d) any person who is an habitual drunkard or a narcotic addict; (e) any person previously adjudged insane or an idiot, imbecile, epileptic or feebleminded, and not restored to competency as provided in paragraph (c) of s. 85.08(1); and, (f) any person afflicted with or suffering from any mental or physical disability or disease that prevents such person from exercising reasonable control over a motor vehicle."

Note sections (b), (d), (e), and (f) above, with special emphasis on section (e), which provides–as did the 1927 law–for blanket license denial for epileptics. This exclusion for epileptics was apparently universal in Europe as well as the United States.

This exclusion of epileptics from licensure was strengthened by a 1947 law requiring Wisconsin physicians to report to the state Board of Health people who were diagnosed as having epilepsy, with this board then required to report to the Department of Motor Vehicles (DMV).

Some physicians, however, supported by the SMS, were successful in getting the 1949 Legislature to modify this position so that Wisconsin became the first state to issue drivers licenses to epileptics on the recommendation of a newly created Medical Advisory Board. Epileptics were eligible for consideration after being free of seizures for 2 years and were required to file medical reports at least every 6 months.

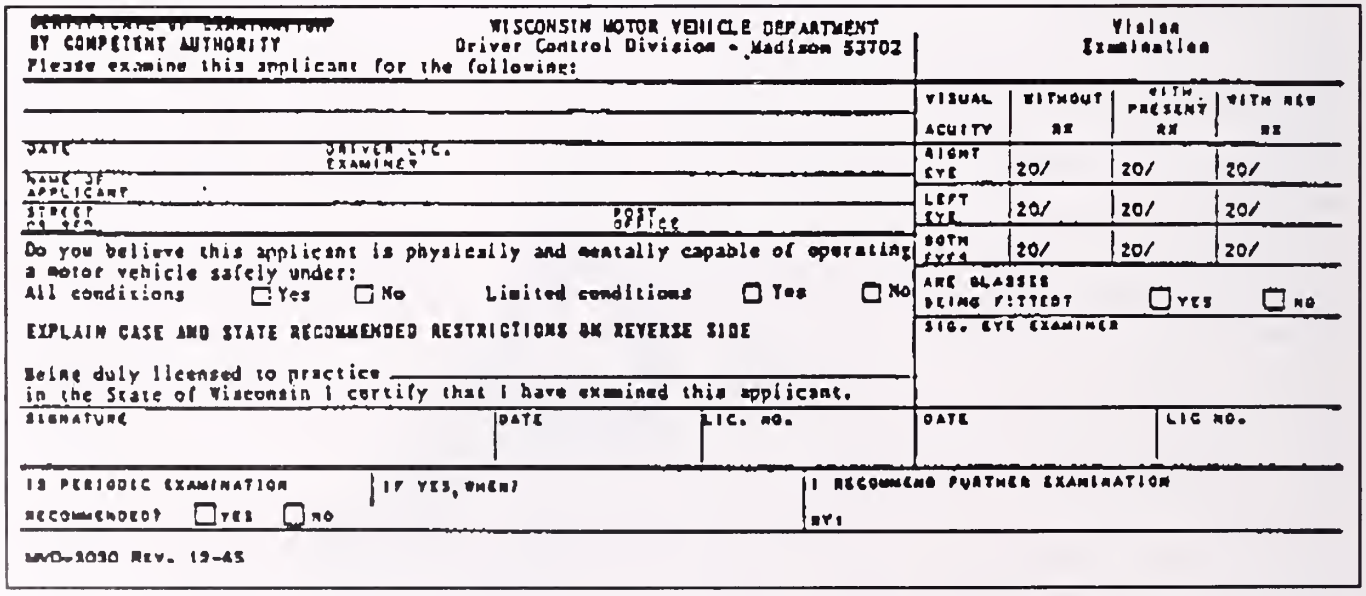
Further significant changes with regard to licensing for epileptics have been adopted in more recent years:

- 1955–mandatory reporting of epileptics repealed;
- 1975–authorized licensure after 6 months seizure-free; and
- 1989–deleted reference to epilepsy from the driver licensing statutes--now refer to "episodes of altered consciousness or loss of body control."

Other medical conditions

The law proscribing licensing for "any person ... with ... mental or physical disability or disease such as to prevent exercising reasonable control over a motor vehicle" was very difficult for everybody to define–drivers, physicians, enforcement people, and courts.

The Figure shows the physician reporting form in use in 1965.[4] There is no guidance here for the reporting physician as to the requirements, mental and physical, for driving safely; similarly, there was little in the medical literature to guide the physician.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BY COMPETENT AUTHORITY
Please examine this applicant for the following:
Vision Examination
DATE
DRIVER LIC. EXAMINER
NAME OF APPLICANT
STREET OR RFD
POST OFFICE
Do you believe this applicant is physically and mentally capable of operating a motor vehicle safely under:
All conditions ☐ Yes ☐ No
Limited conditions ☐ Yes ☐ No
EXPLAIN CASE AND STATE RECOMMENDED RESTRICTIONS ON REVERSE SIDE
Being duly licensed to practice in the State of Wisconsin I certify that I have examined this applicant.
SIGNATURE
DATE
LIC. NO.
IS PERIODIC EXAMINATION RECOMMENDED? ☐ YES ☐ NO
IF YES, WHEN?
I RECOMMEND FURTHER EXAMINATION BY:
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VISUAL ACUITY	WITHOUT RX	WITH PRESENT RX	WITH NEW RX
RIGHT EYE	20/	20/	20/
LEFT EYE	20/	20/	20/
BOTH EYES	20/	20/	20/

ARE GLASSES BEING FITTED? ☐ YES ☐ NO
SIG. EYE EXAMINER
DATE
LIC NO.

Fig–The physician reporting form in use in 1965.

The author attended a 3-day conference on the medical aspects of driver licensure in 1964,[5] sponsored jointly by the AMA, the American Association of Motor Vehicle Administrators, and the US Public Health Service. This was a very frustrating experience as even the experts could not agree on specific limits that would signify who would be presumed capable of driving safely. Reflection on the significance of this leads, inevitably I believe, to the recognition of the almost limitless capability of human beings to compensate for major disabilities (ie, the person born without functional arms who has learned how to safely drive specially equipped vehicles). They are able to demonstrate their competence, and this is as it should be.

The SMS Committee on Safe Transportation has been attempting, since the early 1960s, to help define reasonable licensing standards and reasonable limits for drivers. In 1969, this committee was appointed as Medical Advisory Board to the Wisconsin Department of Transportation and was given six specific charges:

- review medical reporting forms;
- recommend changes or prepare new medical reporting forms;
- develop medical screening standards for DMV;
- prepare standards or guides for physicians regarding driver medical fitness;
- liaison between DMV and medical profession; and
- establish working medical review committees to make recommendations on individual cases.

This committee, usually working with consultants in special fields, has helped the Division of Driver Licensing to develop the standards and reporting forms which are familiar to most readers. There is recognition that these standards do not reflect any scientifically valid epidemiological data because no such data exists; hence, these standards reflect judgmental decisions. Because of the essentially limitless variability from individual to individual in the extent of any impairment, or combination of impairing conditions, and similarly limitless individual variability in ability to compensate to the varying demands of the driving task, it may be that we will never be able to predict future behavior in any individual with sufficient certainty to warrant license denial.

But efforts continue to refine the licensing criteria and testing measures. There have been legislative attempts to define, for society, its expectations:

- 1967–implied consent law;
- 1970–vision examination every 4 years required for licensure;
- 1978–Medical Appeals Board created to allow in-person appearance before a board of physicians who recommend to the administrator;
- 1982–photo licenses, a mechanism that permits trained license examiners to spot gross physical or behavioral abnormalities; and
- 1987–provide immunity for physicians reporting persons with conditions which impair for driving.

Conclusion

The author believes that there are some people who should not be permitted to drive because of medically disabling condition(s), physical or mental or emotional, and that physician involvement in defining the conditions and criteria is essential. But, as we attempt to define these issues, we must remember that far and away the greatest cause of driving impairment is alcohol use and abuse. The goal of these efforts are known, at least vaguely, but they are not in sight.

References

1. Medical examination of chauffeurs. Editorial. *JAMA* 1906;46:1211.
2. Report of committee on physical standards for drivers of motor vehicles. *JAMA* 1924; 83:2094-2095.
3. Chapter 478 Wisconsin Statutes, 1931.
4. Wisconsin Department of Motor Vehicles. 3030 Rev. 12-65.
5. Proceedings. National Conference on Medical Aspects of Driver Safety and Driver Licensing, Nov 16-18, 1964.❑

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

December 1990

Beltran, Luciano R., Elm Grove
*Biros, Dennis G., La Crosse
*Brown, Ward M., Racine
*Calado, Brigido C., Watertown
*Chelius, Carl-Juergen, Cudahy
*Christensen, Dennis D., Madison
*Dedmon, Robert E., Neenah
*Feinsilver, Donald L., Milwaukee
*Fruchtman, Martin Z., Waukesha
Haasler, George B., Milwaukee
Hendrix, Lloyd E., Menomonee Falls
*Hermann, John P., Sheboygan
*Jonas, Eugene R., Ellsworth
*Kanshepolsky, Jose, Racine
*Koltz, Robert L., Marshfield
Laird, Anna K., Madison
*Lichty, James E., Milwaukee
*Majeski, Henry E., Luxemburg
*Mann, Dale H., Elm Grove
*Massick, Stephen A., Fond du Lac
*Myers, Franklin L., Madison
*Olson, David L., New Richmond
*Pederson, John F., La Crosse
Sherman, David M., Milwaukee
*Springer, Errol R., Appleton
*Thatcher, Gregory B., Shawano
*Van Ruiswyk, Jerome V., Milwaukee
*Wepfer, Joseph F., Wauwatosa ❑

Automobile driving and epilepsy: a medical perspective

Phiroze Hansotia, MD, Marshfield

The risks of persons with controlled seizure disorders for traffic safety are reviewed. Previous studies provide insufficient and inaccurate data on this subject. Moreover, the advances in diagnosis and treatment of epilepsy and the improved safety and technology of automobiles and roads have made previous studies out of date and inapplicable to current circumstances. A number of vital questions concerning the determination of safe prognosis remain unanswered. Studies to address these questions and ways of improving future decision making are suggested. *Wis Med J* 1991;90(3):112-115.

THE AUTOMOBILE has been closely associated with the American way of life for almost a century. Medical conditions have been recognized to pose risks for driving since the introduction of automobiles. The first traffic accident attributable to epilepsy was reported by Thalwitzer[1] in 1906. Based on such incidents and the concern for safety when licenses for driving became obligatory, persons with epilepsy were generally omitted from consideration up to the late 1940s. In 1949, Wisconsin was the first state to allow patients with seizures to drive with a license after obtaining certified control of their convulsive disorder.

The evolution of our society made driving important for social, educational, economic, and recreational purposes. The needs of driving vary in the rural and urban population and depend on the type of occupation of the individual but remain important for all. Furthermore, the evolution of medical knowledge and treatment in the diagnosis and control of epilepsy and other medical conditions was also continuous. Improved diagnosis and new drugs for seizure control have vastly improved the outcome of epilepsy. There is also a better understanding of medical illnesses among patients allowing them to adopt lifestyles and correct measures that are in their best interest. This is a continuous process over the past several decades, and these developments have had a continuous and growing influence on the outcome of illnesses affected by them. Studies done 25 and 40 years ago, therefore, dealt with an entirely different medical environment than studies carried out at the present time.

Previous studies on the affects of medical factors on driving safety have shown inconsistent results. In the early 1960s, Treat[2] showed that driver errors, rather than environmental factors, were the cause of accidents in 71% of the cases studied. Waller[3] showed that drivers with chronic medical conditions and alcoholism had higher crash rates than the general public. Hornio reported that licensed drivers with epilepsy had a 1.3 to 2 times higher accident rate than age matched controls. On the other hand, Ysander,[4] in a study performed in Sweden, showed that drivers with diabetes mellitus, heart disease, renal disease, deafness, and reduced vision were no more likely than drivers without these conditions to have accidents and violations.

A number of questions remain unanswered. What is the best "seizure-free interval" on which to base licensure? What is the risk of seizure recurrence after 2 to 5 years of control when medications are withdrawn? What is the difference in this risk between the different groups of epileptics? What is the risk of recurrence in patients with single seizures? How does one compute risk-benefit ratios for commercial vehicles? (Commercial drivers include bus, truck and hazardous material carrier drivers and should pose more of a risk to the public than private vehicle drivers.) Should epileptics face longer seizure-free interval requirements? Be kept on anticonvulsant medications while driving, or be required to provide more frequent certification of their medical condition?

Epileptic seizures sometimes affect consciousness, motor function, or both, but sometimes they affect neither. For this discussion, however--because seizure types are not fixed and may alter, because information for identification is generally inexact and incomplete, and because observers of seizures have varying backgrounds--all seizures will be considered to potentially impair consciousness and the ability to drive or control a vehicle during an attack. By definition, recurrent seizures constitute epilepsy.

People subject to seizures may, for practical purposes, be divided into three groups: those who have suffered a single convulsion; those who have had recurrent seizures or epilepsy which has been completely controlled (definition of complete control to be discussed later); and those who have recurrent seizures or epilepsy which have not been completely controlled. These three groups have different clinical profiles, and appear to have a distinctly different risk for recurrence of seizures. The health related factors that affect these groups also tend to be somewhat different and the degree to which they have been studied varies. For all these reasons, these three groups

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will be evaluated separately with the point of view of: reviewing the available clinical and experimental literature that relate to their specific problem; developing a list of recommendations for regulations as they relate to driving for each group; and developing a list of recommendations to judge the risk of recurrent seizures in these groups.

The risk of subsequent seizures was lower for patients with idiopathic seizures than for those whose seizures had a presumed etiology. Those who were free of seizures for 36 months tended to remain so. EEG abnormalities, abnormalities on neurological examination, and initial partial seizures were identified as significant independent predictors of higher recurrent risks.

The Table shows that, while the risk of seizure recurrence after an initial unprovoked seizure and associated prognostic factors have been examined in several studies[5,6,7,8,11] the interpretation of these findings is impaired by certain features of the study designs employed.[5] Based on this information, the following recommendations are developed for those who have experienced a single unprovoked seizure.

Discussion

Driving should be completely suspended after a single convulsion until a neurological evaluation (as recommended by a formal protocol including a history and physical examination, EEG, appropriate laboratory tests and computed tomography (CT)) is completed and the patient remains free of seizures for a minimum of 3 months following the event. Should abnormalities be found on the initial evaluation, they would be assessed and appropriate recommendations would follow. Anticonvulsant treatment does not necessarily have to be instituted.

If abnormalities are found, the recommendations would depend on further evaluation of those abnormal findings and the decision of the neurologist as it relates to their significance in reference to neurological dysfunction or recurrent seizures. In this group, treatment may be instituted if felt necessary.

A single seizure in association with a metabolic illness, high fever, or other known medical provocation may be considered as follows. Suspension of driving privileges until 3 months after recovery from or control of underlying illness.

The likelihood of a person with a single seizure to have recurrent seizures in the future is smallest if the following are all normal:

- neurological exam;
- electroencephalogram;
- CT scan;
- evidence of systemic or progressive disease; and
- family history.

Since the natural history of an untreated single unprovoked seizure suggests that an increasing percentage of these people are likely to have a second seizure with time, it may be advisable to place them on therapeutic doses of at least one anticonvulsant medication. This treatment may be maintained for a year and then discontinued if there is no recurrence. This recommendation is subject to discussion since there is no universal agreement on the treatment of persons with single seizures with anticonvulsant drugs.

If any of the factors mentioned earlier are found to be positive or abnormal, then treatment should be instituted and maintained for at least 3 years prior to tapering or discontinuing the anticonvulsant medications.

These people may be required to make 6 monthly medical reports for 3 years if completely free of seizures, or for at least 3 years following the complete control of seizures should a second episode occur.

There is a small number of persons who have convulsions only when asleep, most often at night. Some have had nocturnal episodes off and on over a period of years but have never had a diurnal episode. Such people may have their driving privileges restored after a seizure-free interval of 3 months since the risk of daytime seizures in this group seems to be particularly small.

In those in whom seizures are precipitated by specific circumstances–such as: after drug withdrawal—particularly after a long seizure-free interval; a seizure precipitated by psychotropic or other medications prescribed to them for other medical or psychiatric reasons; a single seizure occurring during an acute medical illness in a hospital, or post-operatively–a 3-month period of seizure control may be entirely satisfactory to restore driving privileges. The 3 months of seizure-free interval should follow the complete correction of the offending circumstance that initiated the convulsions. Such a group would require specific authorization by the treating physician.

Studies of single seizures and their risk for recurrence

Author	# Patients	Follow-up	Risk of recurrence 1 yr	3 yr	5 yr
Annegers, et al (1986)	424	5 years	36%	48%	56%
Hauser, et al (1982)	244	2-3 years	12%	27%	—
Harvey & Hopkins (1983)	133	4 years	62%	71%	—

The issue of prognosis in epilepsy has a considerable body of literature associated with it. Numerous studies have been carried out in the US, Scandinavian countries, Great Britain and Japan to name only a few locations. These studies include epidemiological work, done mainly in the US and Scandinavia, as well as several prospective and retrospective studies addressing the issue of seizure prognosis. From these studies, there is fairly widespread agreement that the following factors are associated with seizure control in persons subject to recurrent seizures:

- early age of onset;
- known etiology or cause;
- presence of progressive disease;
- neurological deficit on physical examination;
- below average mental function; and
- seizure type, namely partial complex seizures or generalized tonic-clonic seizures.

These may be developed into a practical rating scale with a total score that can be developed on the various subjects according to the information available. In addition to these medical factors, two subjective factors reported on by the patient's treating physicians could relate to the character and nature of the person affected as to whether they were responsible citizens and as to whether they were compliant with instructions to take medications and other instructions to maintain their health. In combination, these could be developed into recommendations for decisions on driving privileges.

The available literature also showed little, if any, difference between effective seizure control which has been maintained for at least 3 months and effective seizure control maintained for 6 months. The definition of the duration of time required for complete seizure control–to determine whether it is effective enough for a permanent remission–is relatively loose and insufficient. Practical approaches to seizure control aim at using the longest seizure-free interval as a minimum length of time beyond which seizure control must extend in order for it to be considered effective. Other more practical approaches include an arbitrary 6-month, 1-year, or 3-year interval. To resume driving privileges, it seems that a seizure-free interval of 3 months is just as effective or safe as 6 months. Whether this is, in fact, true will only become apparent after a careful prospective study of these recommendations is carried out.

The grounds for preventing some people with epilepsy from driving are derived from information published in some old studies that suggest the accident rate among licensed drivers with epilepsy is 1.3 to 2 times that among age-matched controls with epilepsy.[12,13] Restrictions against driving for persons with epilepsy exist in every state, but these vary considerably. The reason for this variation is the lack of uniform agreement as to the relative risk of recurrent seizures in apparently controlled subjects and in the data required to recognize such risks in these subjects.

It seems appropriate for Wisconsin to develop a prospective study of seizures and driving to cover a span of several years. Such a study could encompass newly licensed drivers who obtain their licenses after driver's education or after graduating from high school. A careful determination of their medical history would identify those with seizures and those who are otherwise healthy into separate groups. Those with seizures who are effectively controlled would be able to receive licenses for unrestricted driving, but their driving records would be followed for several years to determine the risk of recurrence or accidental injury. Such an approach would allow us to develop a risk assessment system based on the best available current information to start out with which could be modified with experience over the next 5-10 years, and accurate accident statistics between those in the seizure population and those without.

The group of patients with uncontrolled seizures is the easiest to consider since its risk for uncontrolled seizures is apparent, high, and by definition, unacceptable–with the possible exception of certain circumstances that may be defined by the board. These circumstances may include driving over short distances in an emergency, for basic life needs, for educational purposes or for employment. The author does not suggest that such privileges be approved but only that these circumstances might be the subject of special consideration in selected cases.

Regulations and laws differ by state because of a lack of current, accurate and balanced data on this subject. Such data should be developed and revised every 10 to 15. These revisions are based mainly on changes in medical practice and improvement in disease control. The Marshfield Clinic-Wisconsin Department of Transportation study is aimed at developing accurate information on the relationship between medical conditions and traffic safety at the present time. This study would be helped by an additional multi-state analysis to confirm and amplify our results.

On the basis of our current study, we hope to be able to make some recommendations as to questions related to driving licenses for private, and possibly commercial vehicles, aimed at providing maximum privilege and opportunity for the individual driver as well as maximum safety for the general public. The recommendations should be reviewed every 5 to 10 years with current and updated material to make appropriate adjustments in legal regulations.

References

1. Van der Lugt, PMJ. Traffic accidents caused by epilepsy. *Epilepsia*. 1975;16:747-51.
2. Treat, GR. A study of pre-crash factors involved in traffic accidents. *HSRI Research Review*. 1980;10:1-35.
3. Waller, JA. *Medical impairment to driv-*

ing. Springfield, Charles C. Thomas; 1973. (Note to author: incomplete citation–need city of publication)
4. Ysander, L. The safety of drivers with chronic disease. *Br J Ind Med.* 1966;23:28-36.
5. Thomas, MH. The single seizure: Its study and management. *JAMA.* 1959;169:457-459.
6. Cleland PG, Mosquera I, Steward WP, et al. Prognosis of isolated seizures in adult life. *Br Med J.* 1981;283:1364.
7. Johnson LC, DeBolt WL, Long MT, et al. Diagnostic factors in adult males following initial seizures: A three year follow-up. *Arch Neuro.* 1972;27:193-197.
8. Annegers JF, Shirts SB, Hauser WA, et al. Risk of recurrence after an initial unprovoked seizure. *Epilepsia.* 1986;27(1):43-50.
9. Hauser WA, Anderson VE, Loewenson RW, et al. Seizure recurrence after a first unprovoked seizure. *N Engl J Med.* 1982;307:522-528.
10. Harvey P, Hopkins A. Views of British neurologists on epilepsy, driving and the law. *Lancet.* 1983;401-404.
11. Hauser WA, Kurland W. The epidemiology of epilepsy in Rochester, Minn: 1935-1967. *Epilepsia.* 1975;16:1-66.
12. Hornio A. Does epilepsy mean higher susceptibility to traffic accidents? *Acta Psych Scand.* 1961;150(suppl):210-212.
13. Waller JA. Chronic medical conditions and traffic safety: Review of the California experience. *N Eng J Med.* 1965;273:1414-1420.❑

Diabetes and the license to drive

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People with diabetes are subject to restrictive licensing policies that bar them from driving certain types of motor vehicles. Discriminatory rules regarding the license to drive are based mainly on concerns that treatment with blood glucose–lowering agents, especially insulin–may induce episodes of altered consciousness due to hypoglycemia. The risk of hypoglycemia, however, differs greatly among insulin-requiring diabetics and it is not difficult to identify those few who present a substantial risk. Moreover, the advent of simple, portable devices for blood glucose self-monitoring allows diabetics to know when blood glucose levels are becoming low and to take prompt corrective action. Thus, it would seem that blanket rules prohibiting diabetics from driving certain types of vehicles are unfair and unwarranted. In view of these considerations, rules are being revised by some licensing agencies to eliminate blanket restrictions and to allow for case-by-case evaluations to determine medical qualifications of people with diabetes.

Tight control of diabetes currently is being advocated widely as a means of preventing chronic complications, but it carries an increased risk of hypoglycemia. Physicians who institute tight control regimens must ensure that patients understand the potential risk of hypoglycemia and are capable of minimizing the risk. Physicians should report patients to the Department of Motor Vehicles (DMV) who, in their judgement, are unable to drive safely because of concerns about hypoglycemia. Wisconsin state law protects physicians who make such reports from liability. *Wis Med J* 1991;90(3):115-118.

People with diabetes have long been subject to restrictive policies affecting their eligibility for employment or licensure relating to employment. They were disqualified for federal employment until 1941, and then federal policy barred insulin-requiring diabetics who took more than 25 units daily from hazardous occupations. Even now, Department of Defense regulations restrict people with diabetes from joining the armed forces and many private employers look upon diabetes as a disqualifying or limiting condition. During recent years, however, employment opportunities for people with diabetes have been expanded as a result of changing societal attitudes about job discrimination based on handicap, backed-up by state and federal anti-discrimination laws.

Title V of the Federal Rehabilitation Act of 1973 states that job discrimination because of handicap is illegal, and diabetes is considered to be a handicap if used as a reason to exclude qualified workers from jobs, promotion or other employment activities.

Diabetics, however, still encounter discriminatory rules regarding their eligibility for licensure to operate certain types of motor vehicle or to pilot aircraft. Transportation departments in many parts of the world require applicants for operator's licenses to reveal that they have diabetes, and diabetics often are restricted from driving heavy commercial, emergency or public transport vehicles.

In the US Federal Highway Administration (FHWA) regulations prohibit insulin-taking diabetics from driving commercial motor vehicles interstate, and Federal Aviation Administration rules deny issuance of an airplane pilot's license to diabetics who take insulin or oral blood glucose lowering agents.[1] FHWA rules have had a determining influ-

ence upon safety standards within the states, because eligibility for federal grants for state highway programs may require states to adopt federal highway safety rules. Adoption of federal regulations regarding medical qualifications would effectively bar insulin-taking diabetics from driving commercial vehicles intrastate.

The discriminatory policies that diabetics encounter in the work place, or when applying for a license to drive, are based mainly on the belief that they may be subject to episodes of altered consciousness due to hypoglycemia. Although this is not an unreasonable concern, it should not be assumed that all diabetics are equally at risk of developing hypoglycemia. Some generalizations can be made regarding the relative risk of hypoglycemia as it relates to the type of diabetes or mode of treatment.

Hypoglycemia does not occur in type II diabetes (ie, non-insulin dependent diabetes mellitus (NIDDM), treated only with diet), and it is unlikely to occur in type II diabetics taking oral agents or obese type II patients who take insulin. Hypoglycemia is most apt to occur in insulin-treated patients with type I (ie, insulin dependent diabetes mellitus (IDDM)), particularly those who have labile or "brittle" diabetes or who are controlled too tightly.

Moreover, hypoglycemic reactions do not lead to sudden loss of consciousness, but ordinarily give ample early warning symptoms and are relieved promptly by ingesting food or drink containing carbohydrates.

Insulin-requiring diabetics ordinarily know how to avoid factors that might promote hypoglycemia, (eg, delayed or skipped meals, exercise, alcohol intake) and are able to use a portable blood glucose self-monitoring device so that they can check to be sure that the blood glucose is at a safe level before driving. A review of the medical history ordinarily will reveal unreliable individuals, those who lack knowledge or self-management skills needed to avoid hypoglycemia, and those who have a record of severe hypoglycemic reactions.

Thus, it would seem that blanket rules that prohibit diabetics from driving certain types of vehicles are unfair and unwarranted. Nonetheless, there still is widespread reluctance among licensing agencies and insurers to ease restrictions that prevent insulin-requiring diabetics from driving certain types of vehicles because of the belief that they have an increased risk of traffic accidents. This belief may be supported by isolated case reports and some retrospective accident surveys which indicate that diabetic drivers have been involved in traffic accidents related to hypoglycemic reactions.

Selected incidents of hypoglycemia-related accidents, however, do not provide information about the risk of such accidents among a population of diabetic drivers. In fact, there is very little reliable data on the influence of diabetes upon driving performance. Studies comparing the rate of traffic incidents between groups of diabetic and nondiabetic drivers have reported both an increased and decreased frequency of incidents in diabetics.[2,3] Most studies have been retrospective, some did not include a control group, and few distinguished between type I and type II diabetes.

One recent well-controlled prospective study evaluated the accident rate in a well-defined group of type I diabetics and a matched group of sibling controls over a 1 year period.[2] The overall accident rate did not differ in the two groups. Currently, a prospective study, sponsored by the Wisconsin DMV is being completed, which may provide more definitive information about driving performance in both type I and type II diabetes.

Based on the limited data available until now, however, it seems inappropriate to impose blanket restrictions on insulin-requiring diabetics on the basis of unsubstantiated fears about risks of hypoglycemia which may be exaggerated and, regardless, do not apply to all diabetic drivers. In the absence of chronic complications, diabetes should not impose any limitation upon physical activity. Insulin-requiring diabetics climb mountains, run marathons, achieve stardom in professional sports; most are capable of operating a motor vehicle safely.

In view of these considerations, and in view of recent advances in diabetes management afforded by the availability of blood glucose self-monitoring devices, some state agencies and the FHWA are taking steps to revise medical qualifications which impose blanket restrictions upon insulin-taking diabetics.

In adopting federal safety requirements in 1987, the Wisconsin Legislature modified the provision which would have barred insulin-requiring diabetics from driving heavy vehicles intrastate, requiring statements from two licensed physicians indicating that the diabetes is not likely to cause loss of ability to control or operate a motor vehicle.

In 1987, the FHWA responded to requests that it consider a rule change which would ease the restriction placed on insulin-using diabetics by soliciting comments from interested parties regarding qualification standards which might be applied. In 1988, the American Diabetes Association (ADA) responded to this solicitation by submitting a petition requesting elimination of the blanket prohibition and recommended a waiver program whereby physicians would make case-by-case determinations of the qualifications of insulin-using diabetics.[4] Also, in 1988, the Office of Motor Carriers (OMC), an agency of the FHWA, sponsored a conference on

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diabetic disorders and commercial drivers, which culminated in a report recommending criteria for medical certification of individuals who develop diabetes after driving 5 years and then require insulin.[5]

In consideration of these recommendations, the FHWA is currently proposing that the blanket restriction against insulin-using diabetics be eliminated and has set-forth criteria for determining individual qualifications which incorporate guidelines contained in the ADA petition as well as the OMC conference report.

In 1986, the Wisconsin DOT revised a rule which denied issuance of a school bus operators license to people taking oral blood-glucose lowering agents or insulin, allowing the Medical Review Section of the Bureau of Licensing to make exceptions based on recommendations by physicians appointed to the Medical Review Board. A preliminary analysis by the DMV of driving performance of diabetic school bus operators who had been approved for licensure following favorable evaluation by the Medical Review Board indicated that the screening procedure was effective. School bus operators taking oral agents or insulin who had been recommended by the Medical Review Board showed a low rate of traffic offenses and accidents.[6]

The Wisconsin DOT is currently proposing a revision of rules relating to medical standards and review process for licensing of drivers. A major consequence of this revision is that functional ability rather than mere presence of a medical condition will be considered as the basis for determining qualification for general licensing (Licensing Category One). The presence of diabetes would be noted only when it results in a reportable functional disability, (eg, altered consciousness, hypoglycemic episodes or other medically disqualifying limitation).

Passenger and school bus endorsements (Licensing Category Two) would require a medical report which would identify individuals as having diabetes or other medical conditions which could affect driving safety, and the Medical Review Board would then make an evaluation to determine whether or not to recommend approval of the endorsement.

Diabetes, and even lesser degrees of impaired glucose tolerance, impart an increased risk of arteriosclerotic cardiovascular disease (ASCVD) which is not relieved by treatment directed at restoring normoglycemia. Accordingly, the recent FHWA proposal includes a recommendation that insulin-requiring diabetics undergo special cardiac examinations, (eg, ECG, exercise stress test, cholesterol measurements) as a condition for certification to drive heavy vehicles. It seems unfair, however, to single out insulin-requiring diabetics for such special consideration, since nondiabetics as well as non-insulin requiring diabetics also may present an equal or even greater risk of ASCVD. If in the interest of highway safety it seems reasonable to screen drivers of certain types of vehicles for ASCVD, the requirement should apply to all applicants who have identifiable risk factors, including hypertension, hypercholesterolemia, cigarette smoking, and obesity.

It is generally agreed that microvascular complications of diabetes are causally related to hyperglycemia, and, accordingly, people with diabetes are encouraged to achieve strict control of blood sugar to prevent or forestall microvascular complications. Even though these complications take years to develop, however, and hyperglycemia may be detrimental to long term health, ordinarily it does not have immediate adverse effects upon mental function or physical performance, and would not momentarily impair the ability to drive. Indeed, diabetic athletes usually allow their blood sugars to run high while engaged in strenuous events to avoid having their activity interrupted or compromised by hypoglycemia.

Physicians are faced with a similar consideration as they attempt to balance concerns about chronic complications against the more immediate risks of hypoglycemia. Current medical opinion holds that tight control prevents microvascular complications, but it also carries an increased risk of hypoglycemia.[7] The recent trend in medical practice is to advocate intensive insulin treatment programs for persons with type I diabetes because prevention of chronic complications seems to outweigh the risk of hypoglycemia, especially since diabetic patients are now able to monitor blood glucose levels frequently and to make adjustments in their management program as needed to avoid hypoglycemia. Nonetheless, intensive insulin treatment programs do result in an increased frequency of severe insulin reactions, and if concerns about hypoglycemia are an overriding issue, it may be necessary to compromise tight control.

An anecdotal illustration may serve to define the dilemma that physicians face as they consider the pros and cons of intensive insulin treatment programs. In treating diabetic patients in the clinic, I am primarily concerned with their long term health. I am constantly harping on them to keep the blood glucose level down; fasting values as low as 70-90 mg/dL and premeal values as low as 70-105 mg have been advocated as "ideal" treatment goals. When I am driving late at night on a slippery, narrow, two-lane road however, and I see approaching headlights, it might just occur to me that the oncoming driver may be an insulin-requiring diabetic. At that moment I would prefer that the driver had been advised to keep his random blood glucose level around 200 mg/dl, perhaps higher.

Summary

The special concern that should be considered in determining whether a person with diabetes is qualified to operate any type of motor vehicle is the potential risk of hypoglycemia that accompanies treatment with

blood glucose-lowering agents. Elevated blood glucose levels may be detrimental to long term health but do not momentarily impair the ability to drive.

Adequacy of control of hyperglycemia is a personal health matter which should be left to the discretion of the individual diabetic preferably under the supervision of a physician, but licensing agencies should not establish rules that are directed mainly toward enforcing what might be considered principles of good health.

Failure to achieve adequate control of hyperglycemia ordinarily should not be considered a disqualifying condition for licensure to operate a motor vehicle. Indeed, any standard that might be set for control of hyperglycemia not only would be arbitrary and unfair, but depending upon how low a standard is set, would run counter to concerns about highway safety because it would tend to increase the risk of hypoglycemia. Chronic diabetic complications may impair the ability to drive, but these are covered by general medical requirements which apply to all drivers.

In the absence of reliable data about driving performance of persons with diabetes, it is reasonable to assume that treatment with blood glucose lowering agents may confer a potential risk of increased accidents due to hypoglycemic reactions. This risk differs greatly, however, among diabetics depending upon the type of diabetes, mode of treatment, as well as their compliance with a reasonable treatment program and general reliability. Individual case-by-case review of applicants can identify those who present a serious risk of hypoglycemia and they should not be licensed to drive. With a reasonable management program, which should include blood glucose self monitoring, there should be a negligible risk of hypoglycemia.

Accordingly, in exercising their privilege to drive, diabetics must assume personal responsibility for managing their diabetes in such a manner as to avoid hypoglycemia while driving. Control of hyperglycemia may have to be compromised in the interest of public safety. "Driving while hypoglycemic" should be considered a serious violation and should result in legally enforced remedies, including loss of license to drive. In the United Kingdom, it is a chargeable offense to drive while impaired by prescription drugs, including insulin.

Physicians must assume responsibility for instructing patients who take blood glucose-lowering agents about risks of hypoglycemia and ensure that they have acquired self-management practices needed to minimize this risk. Physicians who institute a program of tight control in a patient lacking motivation or self-discipline or without providing concomitant education about risks of hypoglycemia may be held responsible for harm that may result to the patient or third party.[8] Physicians should report patients to the Division of Motor Vehicles (DMV) who present a risk of hypoglycemia. Wisconsin state law protects a physician who makes such a report from liability.

Finally, the DMV should establish a procedure for determining whether insulin-using diabetics who have been subject to hypoglycemic episodes have acquired the knowledge and self-management practices needed to avoid hypoglycemia before being approved for a license to drive.

References

1. FHWA Regulations. *Federal Register.* April 22,1970;49:391.41(b)(3).
2. Songer TJ, LaPorte RE, Dorman JS, et al. Motor vehicle accidents and IDDM. *Diabetes Care.* 1988;11:701-707.
3. Ratner RE, Whitehouse FW. Motor vehicles, hypoglycemia, and diabetic drivers. *Diabetes Care.* 1989;12:217-222.
4. American Diabetes Association Petition to the Department of Transportation. FHWA Docket #MC 87-17, filed October 1986.
5. Report No FHWA/MC-88/041. Conference on Diabetic Disorders and Commercial Drivers. FHWA, Office of Motor Carriers, US Department of Transportation. Washington, DC, March 1988.
6. Communication: Medical review section, Bureau of Licensing, Wisconsin Department of Motor Vehicles. *Preliminary analysis of driving behavior of Medical Review Board school bus and chauffer appellants.*
7. The DCCT research group. Diabetes control and complications trial (DCCT): Results of feasibility study. *Diabetes Care.* 1987;10:1-19.
8. Palmer LI. Ethical and legal implications of diabetes self-management. *Practical Diabetology.* 1989;8:1-3.❑

A legislative view of driving and legal restriction

David Helbach
Wisconsin state senator
Stevens Point

As a member of the Wisconsin Legislature for the past 12 years, I have had the opportunity to help shape public policy in a wide range of subject areas, and one of the more fascinating topics I have dealt with was the state's role in regulating the ability of medically impaired people to operate motor vehicles.

Although there are many medical conditions that may affect a person's ability to drive, much of my work has involved traffic laws relating to epilepsy and other seizure disorders. I will, therefore, focus primarily on this subtopic while attempting to highlight the broader policy implications.

Wisconsin has a very interesting historical perspective on driver licensing of persons with epilepsy. In 1927, the first driver's license was required in Wisconsin. The Legislature didn't waste any time identifying who could and could not receive licenses. In 1928, Act 478 created Wisc Stat 85.08(1)(c), which states that "any person who has previously been adjudged insane or an idiot, imbecile, epileptic or feeble minded ... may not be issued a license." Amazing as that language may seem, it reflected the thinking of the time with regard to epilepsy.

In 1941, Act 206 made substantial revisions in the state's driver licensing law. No change, however, was made in the law's references to epileptics. Then in 1945, a seemingly minor but important change was made. Act 97 pulled the word epileptic out of Section (1)(c) and placed the prohibition of driver's license for epileptic persons in its own section of the state statutes. Although this was a subtle distinction, it would set the stage for next major revision in our law.

In 1949, Wisconsin broke ground and became the first state in the nation to allow persons diagnosed with epilepsy to be issued a driver's license. The new law, Act 85, set forth very strict conditions to be followed, and initially allowed only for the issuance of temporary permits.

Over the next 30 years, a few minor revisions were made to Wisconsin's law. In 1957, and again in 1973, changes were made in the procedures set forth for the Medical Review Board. In 1975 and 1977, bills were passed reducing the amount of time that a person with epilepsy would need to be seizure-free before obtaining a license.

In 1983, my involvement with this issue began. I was contacted by a constituent who had been free of seizures for 22 years, yet still had to file an annual medical report with the Department of Transportation (DOT) to keep her driver's license. In response, I drafted and introduced legislation to eliminate the annual report requirement for people who had been seizure-free for at least 10 years. Several months later, Gov Anthony Earl signed Act 431 into law.

In the summer of 1986, after consultation with a number of state officials and advocacy groups, I formed an Ad Hoc Committee on Epilepsy. This committee was charged with taking a comprehensive look at all of our state laws relating to epilepsy. Although we studied four major issue areas (insurance, employment, transportation, and developmental disabilities) a great deal of our time and energy was devoted to a proposed revision of driver licensing requirements for persons with epilepsy.

Wisconsin statutes continued to single out persons with epilepsy, and treat them differently than persons with other types of medical disorders that could affect one's ability to drive. The ad hoc committee recommended legislation to eliminate all references to epilepsy in the driver licensing statutes, thus putting people with epilepsy on equal footing with those who have other medical disorders. The committee's proposal would also allow for voluntary, good faith reporting by physicians of people with sei-

Continued on next page

State Sen David Helbach, from Stevens Point, represents District 24. Sen Helbach is the majority leader in the Wisconsin Senate. Reprint requests to: State Senator David Helbach, P.O. Box 7882, State Capitol, Madison, WI 53707. Copyright 1991 by the State Medical Society of Wisconsin.

Continued from preceding page
zure disorders that may affect their ability to drive. In addition, it directed the DOT to reduce the minimum waiting period for license reinstatement following a seizure from 6 to 3 months, and created a new "voluntary surrender" license status. All of these changes became law as part of 1987 Act 40.

Making laws can often prove to be a very difficult balancing act, and the legal restriction of driving privileges is certainly no exception. In the case of persons with epilepsy, legislators need to strike a balance between the strong public safety interest in keeping potentially dangerous drivers off the road, and the rights of individuals not to be unfairly discriminated against because of their medical conditions.

One important factor to keep in mind is that the Legislature at any given time is a reflection of our society as a whole. So, in 1928 when laws were written to severely discriminate against individuals with epilepsy, the laws were representative of the beliefs and misconceptions about epilepsy that were widely held at the time.

By the same token, the gradual easing of state restrictions on people with epilepsy that can be controlled represents a change in the way these disorders are now viewed by society--and I believe the medical community deserves a great deal of credit for this change.

Unfortunately, we still have a long way to go in eliminating the public's misconceptions about seizure disorders. I do believe, however, that progress is being made.

Aside from dealing with misconceptions about, and sometimes prejudice against individuals with, seizure disorders, there are other problems that developed over the course of working on this issue.

A key problem that individual legislators often face is the lack of specific knowledge about a particular topic. All legislators are forced to be generalists–that is, to know a little bit about a great many issues. As we formulate public policy, therefore, we must rely heavily on those with the proper expertise in a given area. In this instance, neurologists, traffic safety experts, and individuals with epilepsy provided valuable information as we moved through the process.

Another problem often faced when dealing with issues is the lack of continuity within the Legislature. The average length of time served in office by a state legislator is now about 6 years. This means that our institutional memory is not nearly as great as it once was. Therefore, we often need to educate, or re-educate, legislators about the history of a given issue.

Finally, the tendency to react quickly in an attempt to solve a given problem can cause further problems. As a colleague of mine once said, "The status quo is no accident; somebody put it there for a reason." Often, in our haste to fix a perceived "broken" law, we tend to ignore the reason it was set up a certain way in the first place. Obviously, no law is perfect, and many laws do need updating from time to time. Fortunately, the legislative process is designed to foster a reasoned, rational approach to legislative changes.

As we move through the '90s and into the next century, the Legislature will have to continue its balancing act between public safety interests and individual liberties. The licensing of drivers with certain medical conditions is but one of many such issues that will demand our attention.

I believe the medical community will continue to play a pivotal role in this area of public policy, and I would encourage the continued involvement of those who have an interest in this topic.

Acknowledgements

Special thanks to the Legislative Reference Bureau for its assistance with this project.❑

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Public health

Risk factors for lung cancer: a pilot study in five counties

Patrick Remington, MD; Henry Anderson, MD; Larry Hanrahan, MS; and Linda Haskins, Madison

CIGARETTE SMOKING has been identified as the single most important cause of lung cancer, accounting for an estimated 85% of all cases. More recently, other risk factors have been identified, including environmental tobacco smoke (ETS), occupational exposures, and radon. In this report, we describe the results of an investigation of the potential causes of lung cancer deaths in five counties in Wisconsin. As part of the project funded by the Centers for Disease Control, we investigated the 1987 deaths occurring among people 65 years of age or younger that were due to one of five potentially environmentally caused cancers (lung, liver, oral, bladder or childhood leukemia).[1] Questionnaires were mailed to the next-of-kin in January 1990, with two reminder letters sent to non-responders in February. This report summarizes the information pertaining to the lung cancer deaths. Of the 76 questionnaires sent out, eight were undeliverable. Of the remaining 68, 55 (81%) were completed and returned. The cases ranged in age from 37 to 65 (median age 59). Thirty-nine (71%) were male.

Background

All but two of the cases smoked at some time in their life (Table 1). Of the 53 cases who had ever smoked, most (70%) had quit smoking prior to the diagnosis of lung cancer (Table 2). Most of those who had quit, however, did so only a few years prior to being diagnosed with lung cancer. Only four (11%) had quit more than 10 years prior to diagnosis. In addition, almost two thirds of those who had ever smoked had more than a 50 pack-year history of smoking (pack-year equals number of packs smoked per day multiplied by the number of years smoked).

Environmental tobacco smoke (ETS). About half (49%) of the cases in this study were exposed to tobacco smoke in their homes because of a spouse who smoked. No information was available about exposure to tobacco smoke in the work place. Five individuals, however, were employed as bartenders or waitresses and were likely to have been exposed to significant amounts of ETS. In addition, eight reported working in office environments. Prior to current clean indoor air regulations, ETS exposure was also likely for these individuals.

Occupational exposures. Sixteen (29%) of the cases reported occupations which probably involved exposure to known lung carcinogens such as asbestos, polycyclic aromatic hydrocarbons, and other chemicals. These occupations included steel workers, roofers, plumbers, building and plant maintenance occupations, and welders. In addition, six cases were truck drivers who were likely exposed to diesel fuel exhaust, a known lung carcinogen.

Family history. Nearly a quarter (24%) of the cases in this study reported that a first degree family member (parent or sibling) had been diagnosed with cancer.

Radon. Only three of the cases had ever had their homes tested for radon and one of them had a level of 9.6 pico curies (twice the EPA recommended action level). This person was himself a smoker, had a wife who smoked, was exposed to asbestos and diesel exhaust in the work place, and had a family history of lung cancer.

Continued on page 124

From the Chronic Disease Surveillance Unit, Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Dr Anderson is chief of the section; Dr Remington is principle investgator of the project. Hanrahan is a unit spervisor in the section and Laskins is an epidemiologist and public health educator. Address reprints requests to: Patrick Remington, MD, Wisconsin Division of Health, 1 W Wilson St., PO Box 309, Madison, WI 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin.

Series coordinators
The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of the Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, Wisconsin Division of Health are coordinating this series for the *Wisconsin Medical Journal.*

Table 1.–Risk factors identified among 55 persons who died from lung cancer in Wisconsin, 1987.

Risk factor		
Ever smoking (includes 3 pipe/cigar smokers)	53	96%
Passive smoking	27	49%
Occupation*	16	29%
Family history of lung cancer	13	24%
Radon	1	2%

* Includes occupations with probable exposure to lung carcinogens, such as asbestos, polycyclic aromatic hydrocarbons, or other chemicals

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Am Fam Phys 1987;36:133-140

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of non-susceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
• Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Continued from page 122

Summary

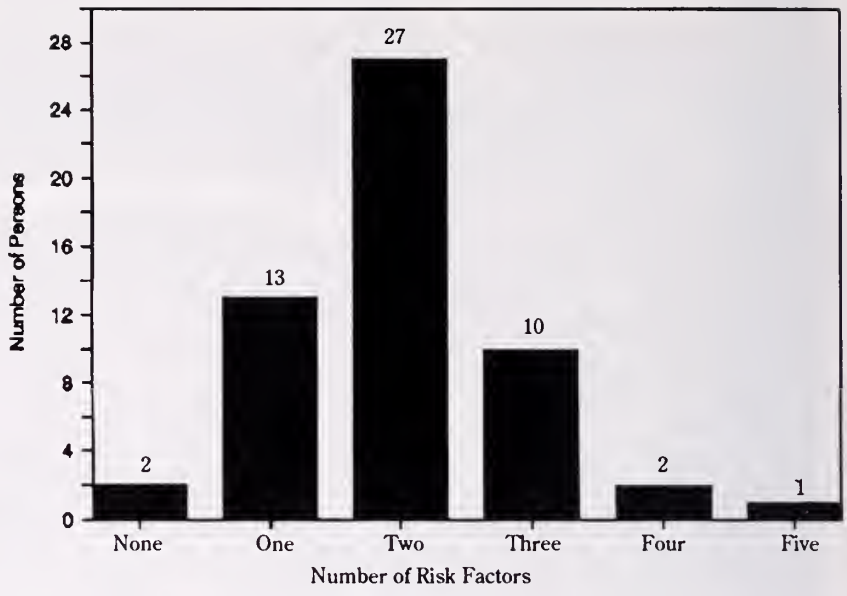
Behavioral, occupational and environmental risk factors play a major role in the etiology of lung cancer. Although the presence of a risk factor does not prove causation, it suggests that this death might have been prevented or delayed if the risk factor had not been present. Although the findings presented here are not unexpected, they raise several important issues.

First, although smoking is the most common cause of lung cancer, it is not the only one. For two of the cases, no risk factor could be identified (Fig). In addition to smoking, most of the cases had at least one identifiable risk factor. The presence of these other risk factors–such as a high risk occupation, family history or exposure to radon–acts to synergistically increase the risk of developing lung cancer among cigarette smokers.

Second, the finding that a large percentage of the cases had a family history of lung cancer deserves further study. A recent report in the *Journal of the National Cancer Institute* demonstrated that some individuals inherit a predisposition to lung cancer.[2] Smokers with a family history of lung cancer should be advised of their increased risk and should be especially pressed to quit smoking.

Finally, the existing death registration system does not adequately document the presence of risk factors for lung cancer. Despite the clear contribution of smoking to these lung cancer deaths, only three death certificates even mentioned cigarette smoking as a contributing cause. Several states have added a separate question about tobacco use to the death certificate to increase the reporting of tobacco use and aid in assessing the causes of death.

A major function of public health is to determine the causes and potential for prevention of illnesses, injury, or death. Information about risk factors which possibly contributed to a person's death should always be listed on the death certificate. Physicians are the most knowledgeable about the patient and the causes of disease and serve as a vital source of this information.



Fig–Number of risk factors among persons dying from lung cancer in Wisconsin, 1987.

Table 2.–Smoking status and lifetime tobacco exposure among persons who died from lung cancer in Wisconsin, 1987.

Smoking status at time of diagnosis		
current smoker	16	29%
former smoker*	37	67%
never smoked	2	4%
Time since having quit smoking**		
<=1 year	15	41%
2-4 years	10	27%
5-10 years	8	22%
>10 years	4	11%
Number of pack-years***		
<=50 pack years	17	37%
51-74 pack years	17	37%
75+ pack years	12	26%

* Includes former pipe/cigar smokers
** Among former smokers (n=37)
*** Among ever smokers with information on amount and years smoked (n=46)

Acknowledgments

The authors appreciate the assistance of Dennis Anderson, Dan Peterson and Paula Lantz in reviewing this manuscript.

References

1. Anderson HA, Remington PL, Hanrahan LP, et al. Surveillance of environmental disease: The Wisconsin initiative. *Wis Med J.* 1990;89:120, 122,124.
2. Caporaso NE, Tucker MA, Hoover RN, et al. Lung cancer and the debrisoquine metobolic phenotype. *J Natl Cancer Inst.* 1990;82:1264-1272.❑

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HMO financial reports

THE YEAR-END STATEMENTS for the third quarter of 1990 for Wisconsin's HMOs are outlined in the following chart. The report was provided by the Office of the Commissioner of Insurance (OCI). Numbers do not tell the whole story, so physicians requiring further information should contact either the OCI or the chief financial officer of the HMO in question.

Recognizing that the report does not give physicians current or perfect information on the HMO's financial performance or stability, and that recent legal changes have increased the incentive for HMOs to enter into hold harmless agreements with physicians, the State Medical Society sought to provide greater accountability of HMO administrations to their contracting physicians.

Office of the Commissioner of Insurance HMO 1990 annual statement summary–3rd quarter–unaudited

	Total Assets	Total Liabilities	Net Worth	Total Revenue	Total Expenses	Net Income	Enrollees
Aetna	3,808,203	3,143,109	665,094	8,566,067	11,504,043	(1,939,066)	10,176
Compcare	25,455,984	18,436,581	7,019,403	122,501,859	120,864,625	1,297,187	152,896
Dean	32,820,613	22,440,455	10,380,158	89,747,583	83,050,906	4,162,837	107,930
Family	44,423,605	22,977,860	21,445,745	78,879,995	75,977,320	2,902,675	85,131
GHC-EC	4,688,104	3,712,163	975,941	14,011,606	13,830,126	181,480	14,076
GHC-SC WI	12,870,442	8,428,904	4,441,538	27,421,670	25,293,937	2,127,733	35,213
GLHP	1,339,011	729,121	609,890	3,129,755	3,161,008	(30,153)	4,551
HMO Mid	3,519,669	1,980,852	1,538,817	9,228,843	8,550,026	738,817	9,037
HMO of WI	7,722,996	4,811,435	2,911,621	30,995,737	29,732,892	769,845	36,949
Maxicare	5,112,483	2,229,631	2,812,542	17,331,609	17,458,377	(126,768)	18,902
Med Assoc	775,433	109,630	665,803	2,816,681	2,715,102	101,579	2,857
Metlife	2,365,008	1,663,094	731,914	3,176,944	3,546,066	(373,122)	2,242
Midelfort	4,982,746	3,298,442	1,684,304	18,750,301	17,279,540	858,845	22,236
Network	4,100,182	2,919,786	1,180,396	19,602,815	18,924,774	406,761	24,374
NCHPP	11,889,315	7,336,016	4,553,299	26,559,329	25,332,649	1,226,680	30,466
Phys Plus	5,432,563	3,401,543	2,031,020	52,482,813	52,270,714	99,417	58,771
Primecare	28,673,959	24,684,223	3,989,736	79,558,444	79,861,007	(636,854)	99,750
Samaritan	16,431,733	11,818,861	4,612,872	60,528,375	60,532,417	(49,042)	75,234
Security	20,283,012	15,364,577	4,918,435	66,088,295	64,736,327	1,351,968	75,523
U-Care	4,851,891	3,202,856	1,649,035	11,584,778	10,644,803	939,975	14,216
United	2,918,511	2,149,218	769,293	12,145,134	12,336,405	(191,271)	16,720
WHOIC	25,331,774	19,418,199	5,913,575	91,315,869	87,224,187	2,610,196	115,817
EHIC	N/A	N/A	N/A	26,217,163	25,729,771	297,309	29,718
Q-Care	N/A	N/A	N/A	9,600,790	9,443,712	157,078	10,141
Allhealth	N/A	N/A	N/A	2,739,389	2,726,115	13,274	1,979
WHPP-EC	N/A	N/A	N/A	2,779,034	3,084,188	(305,154)	2,236
WHPP-Gr Bay	N/A	N/A	N/A	20,837,056	19,768,151	1,068,905	22,496
WHPP-Oshk	N/A	N/A	N/A	4,276,779	4,734,789	(458,010)	4,347
WHPP-Wis Rap	N/A	N/A	N/A	963,327	915,364	47,963	1,240

Annual meeting offers a full agenda

The SMS 1991 annual meeting promises to be as informative, as stimulating and as entertaining as any you've attended. This year's theme is: "Being an effective physician (despite the hassles of medical practice)."

This year's program has two important differences from those of the recent past. First, in response to popular demand, the opportunities to peruse the exhibit floor have been enhanced. The exhibition area will now be open on Thursday as well as Friday and Saturday morning. The world of medicine evolves quickly, and the SMS exhibit floor is one of your best chances to stay abreast.

Second, this year you are invited to a free Presidential Inauguration Ceremony and Reception, instead of the familiar Presidential Dinner. The ceremony will introduce the Society's incoming officers, and the reception will allow you to meet them in a more social setting.

Some things remain the same. The reference committees and House of Delegates will conduct the official business of the Society and chart its course for the coming year, the scientific and socioeconomic sections will delve into the timely theme, and the Fifty Year Club will honor those who have practiced medicine for half a century.

Day-by-day, hour-by-hour guides to the annual meeting events can be found on pages 128, 130 and 131 of this issue of *Wisconsin Medical Journal*. ❑

FIFTH ANNUAL

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Session I	Jay D. Haley, M.A.	Directive Therapy
Session II	Peter E. Sifneos, M.D.	Short Term Dynamic Psychotherapy

July 29-August 2, 1991

Session III	Donald Meichenbaum, Ph.D.	Cognitive Therapy
Session IV	MCW Department of Neurology	Neurology for Non-Neurologists

August 5-9, 1991

Session V	John H. Greist, M.D.	Anxiety Disorders and Their Treatment
Session VI	Robyn S. Shapiro, J.D. Charles L. Junkerman, M.D.	Medical Ethics in Clinical Practice

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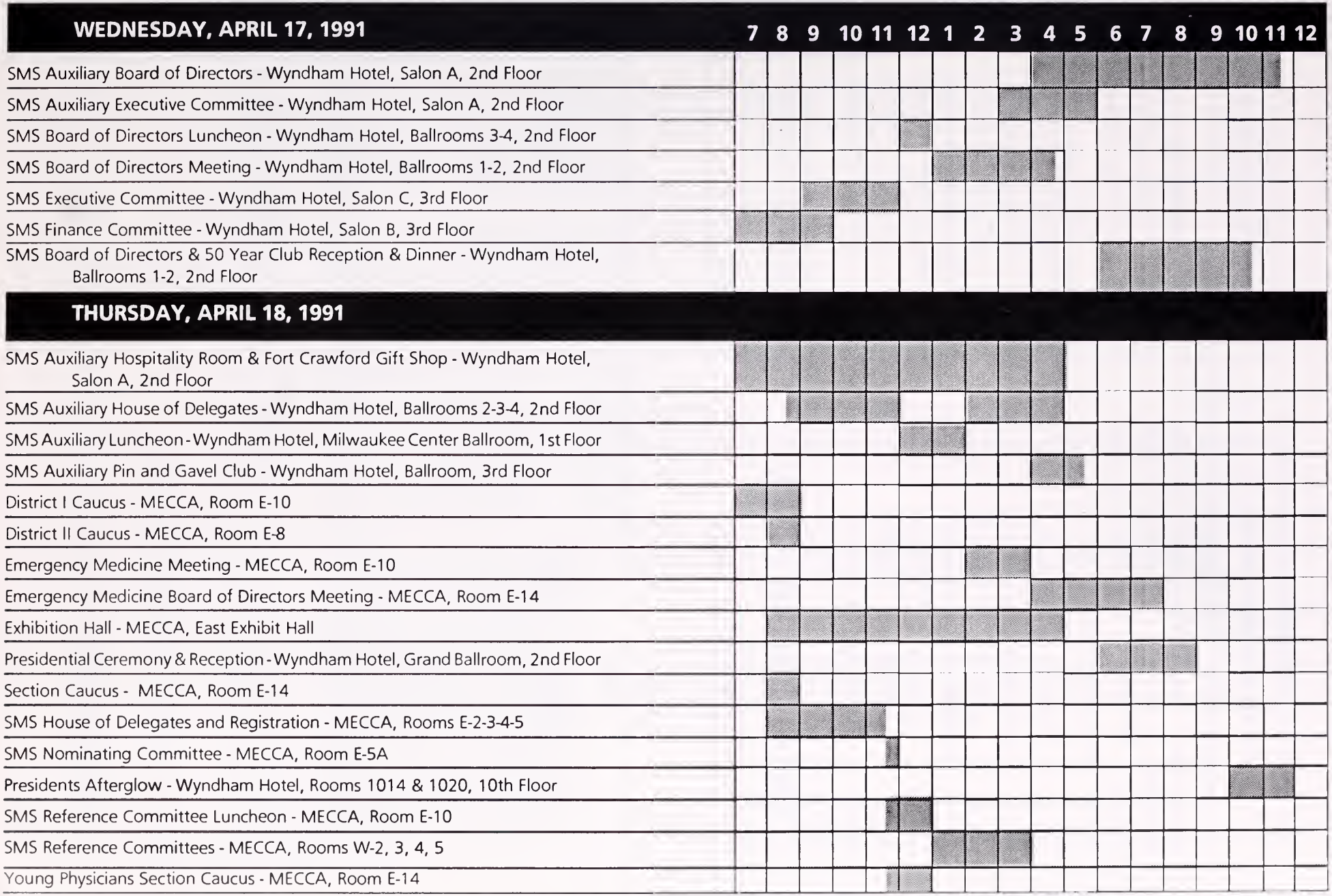

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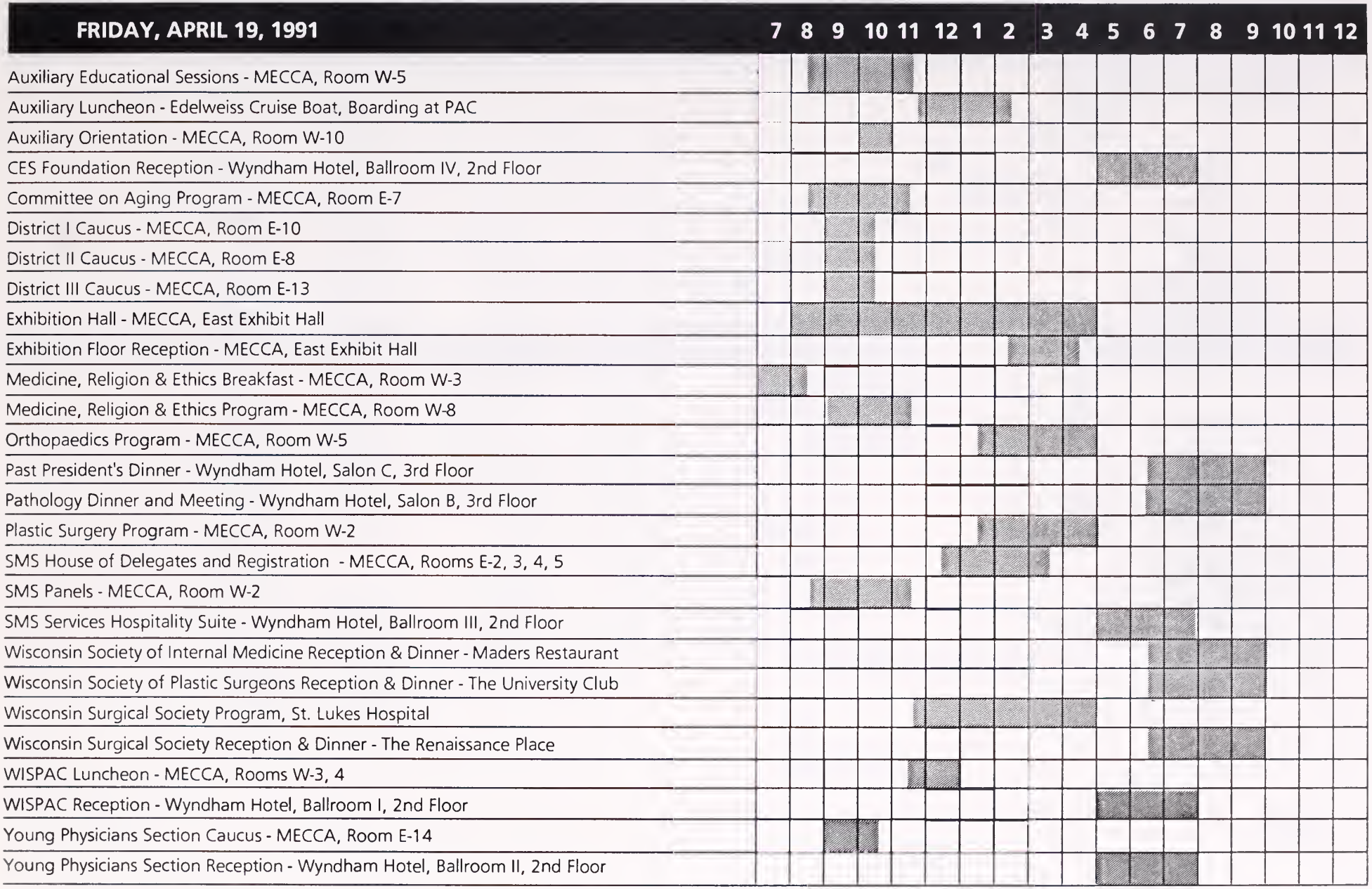

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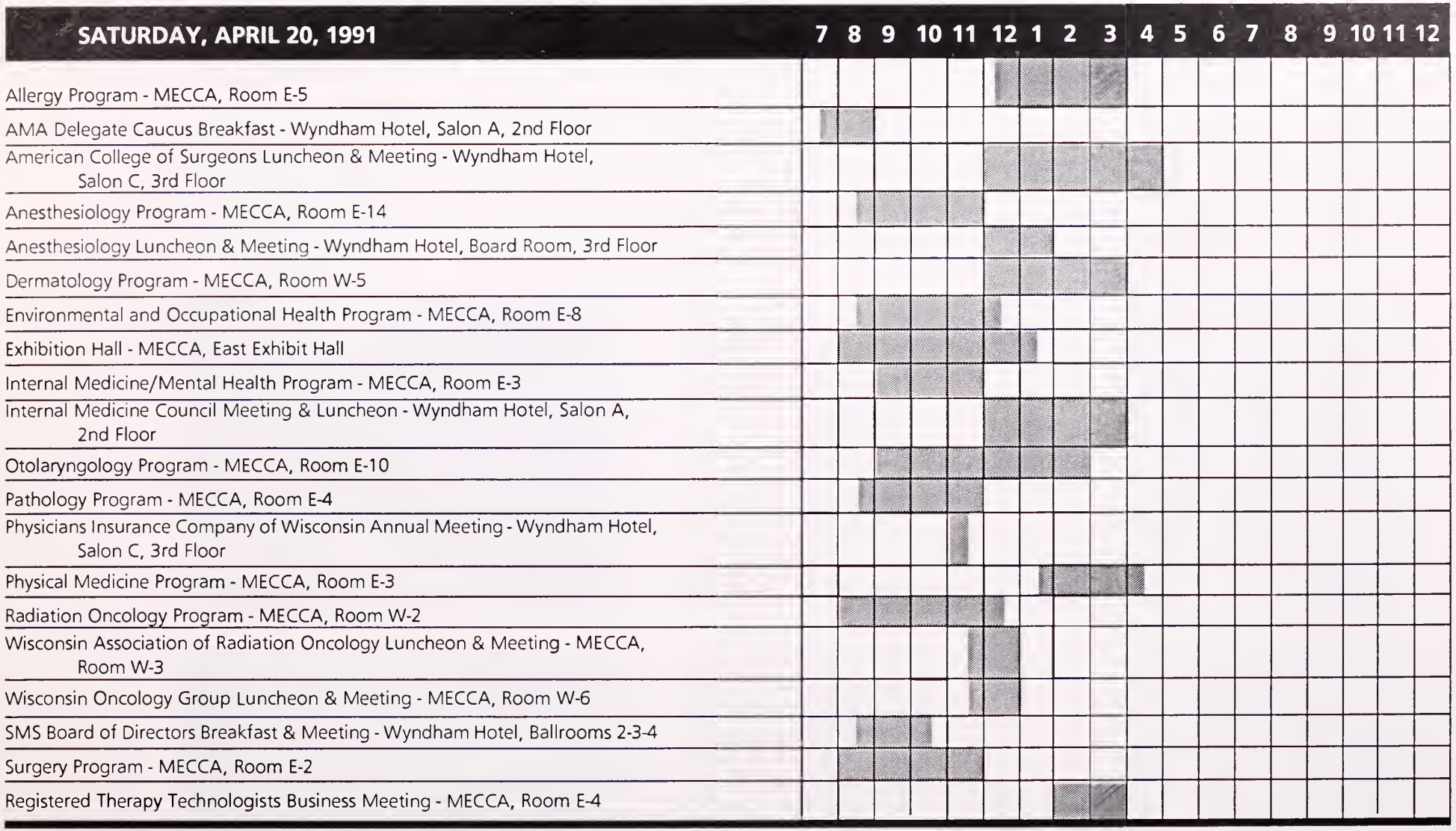

Physician briefs

The * indicates SMS members.

John C. Borkovec, MD,* of Franklin, and **Donald C. Nimmer, MD,*** of Greendale, recently developed Parkland Family Physicians. Both are recent graduates of St Luke's Family Practice residency program in Miwaukee. Dr Borkovec and Dr Nimmer, family physicians, attended the Medical College of Wisconsin.

Larry Sherkow, MD,* of West Bend, has joined the Milwaukee Medical Clinic's radiology staff. Dr Sherkow received his medical degree fron the New York Medical College in 1975 and served a residency in diagnostic radiology at the Medical College of Wisconsin.

John P. Kampine, MD, PhD

Jacob Lemann, Jr., MD

John P. Kampine, MD, PhD*, professor and chair of the department of anesthesiolgy and professor of physiology, and **Jacob Lemann, Jr, MD,*** professor of medicine and chief of the nephrology division, of Milwuakee, will receive distinguished service awards from the Medical College of Wisconsin at the school's commencement exercises May, 18, 1991. Dr Kampine, joined the Medical College of Wisconsin faculty in 1967 and became chair of the department of anesthesiolgy in 1979. Dr Lemann joined the Medical College of Wisconsin faculty in 1963.

Louis W. Sullivan, MD, US secretary of Health and Human Services, will deliver the the commencement address at the MECCA auditorium.

Cassandra Pollard Welch, MD,* of Milwaukee, and **William Walker, MD, PhD**, will be presented the 1991 Public Interest Awards for Health Advocacy. The award is given by the Center for Public Representation, Inc, a nonprofit organization dedicated to speaking up for the unrepresented. Dr Welch specializes in internal medicine.❑

County society news

Dane. The following physicians were accepted to membership in the society: David G. Alexander, MD; Dwayne M. Griffin, DO; Mohammad E. Rassouli, MD; Sheila K. Thakor, MD; Gregory R. Trost, MD; and Raymond K. Tu, MD.

Grant. Mark A. Hughes, DO, of Lancaster, has been accepted to membership in the society.

Milwaukee. Carol J. Danninger, MD, of Brookfield, has been accepted to membership in the society.

Vernon. Phillips T. Bland, MD, Westby, was the guest speaker at the January meeting of the county society meeting. His topic was biomechanics of ski jumping injuries and fatalities. Fifteen members and their guests were present, including Jack Biller, representative of the Eli Lilly & Company.

Winnebago. Thirty-six members and area dentists attended the January meeting of the county society meeting. John H. Duffy, DDS, was the guest speaker and his topic was dental wellness. Zenown Abouzelam, MD; Gregory A. Kozney, MD; and Andrew Greenfield, MD, were accepted to membership. ❑

Obituaries

Dean M. Dreblow, MD, 37, of Onalaska, died Dec 17, 1990, in Onalaska. Dr Dreblow was born Nov 17, 1953, in Rochester, Minn. He graduated from the Mayo Medical School in Rochester, Minn, and served his residency with the St Francis-Mayo Family Practice program. He became associated with the Skemp Clinic in 1983. Dr Dreblow was a member of the American Academy of Family Physicians, the La Crosse County Medical Society, the SMS, and the AMA. Surviving is his mother, Ann, of Rochester, Minn.

Ronald K. Kalkhoff, MD, 57, of Cedarburg, died Dec 20, 1990, in Port Washington. Dr Kalkhoff was born Dec 6, 1933, in Milwaukee, and graduated from the Washington University School of Medicine, St Louis, Mo. His internship was served at St Louis City Hospital and his residency completed at Barnes Hospital in St Louis. Dr Kalkhoff was professor of medicine and pharmacology at the Medical College of Wisconsin, where he served as chief of the division of endocrinology and metabolism from 1974 to 1988. He founded the Diabetes Care Center at Froedtert Memorial Luther Hospital. Surviving are his widow, Rhea Lynn; two daughters, Stephanie Long, and Cynthia; and two sons, Richard and William.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑

Bradley W. Poulson, MD, 37, of Two Rivers, died Dec 27, 1990, in Milwaukee. Dr Poulson was born June 21, 1953, in Tecumseh, Mich, and graduated from the Wayne State University School of Medicine. He practiced in the Manitowoc-Two Rivers area for the past 9 years. He also was the medical director of Health Fast at Memorial Hospital. Surviving is his father, Ramon, of Osseo, Mich.

Ursula Kutter, MD, 71, of Milwaukee, died Dec 28, 1990, in Milwaukee. Dr Kutter graduated from the University of Munich Medical School, Germany, and served her internship at St Luke's Hospital in Milwaukee. Her residency was completed at Columbia Hospital in Milwaukee. Dr Kutter had been associated in medical practice at St Mary's since 1963. She was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are three children, Col Wolf Kutter, Daniel Wyatt, and Chris Kutter.

F. Frank Zboralske, MD, 84, of Fall Creek, died Dec 29, 1990, in Eau Claire. Dr Zboralske was born June 20, 1906, in Manitowoc, and graduated from Marquette University Medical School. He served his internship at Madison General Hospital (now Meriter). Dr Zboralske opened his medical practice in Fall Creek in 1931 and retired in 1988. He served in the US Army during World War II. He was a member of Eau Claire-Dunn-Pepin County Medical Society, the SMS, and the AMA. Surviving is one son, Dr F. Frank, of Sutter Creek, Calif; four grandchildren, and two great-grandchildren.❑

Grants available for community health projects

The Wisconsin Chapter of Pediatrics Accident and Poison Prevention Board is sponsoring three grants of $500 each to fund community projects that show the greatest merit in the following areas:

- increase in the use of bicycle helmets in children;
- increaseing bicycle safety and awareness in children; and
- programs that will continue in the community on an annual basis.

Grant applications must be received by May 1, 1991, at: Kathleen M. Barkow, MD, Webster Clinic, 900 S. Webster, Green Bay, WI 54301.

The grants will be awarded by May 31, 1991.❑

CES Foundation contributors: 1990

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation for the year 1990.

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In recognition of those individuals, county medical societies and auxiliaries who contribute their support to the Fort Crawford Medical Museum.

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"The Right Touch" - Child Abuse Coloring Book
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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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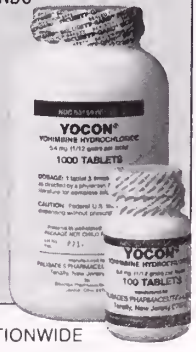

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Recent actions of the SMS Board of Directors

At the Feb 23, 1991, Board of Directors meeting, the Board approved the proposed 1991 SMS budget and forwarded it to the House of Delegates. The Board also approved a $3 dues increase for residents for 1992, and will recommend to the House a regular members dues increase of $15.

In addition, the Board approved the Executive Committee's recommendation to adopt amendments to the 1988 Strategic Plan, based on a 1990 membership survey. In other matters, the Board:

- approved the Physicians Alliance Commission recommendations, which included: supporting Medicaid reimbursement increases; seeking to modify DHSS' proposed program for bulk purchase of vaccines for Medicaid patients of private physicians assuring adequate reimbursement for vaccine administration; expanding, if possible, the bulk purchase program to make vaccines available, at the cost incurred by the state, to all physicians for immunization of both Medicaid and non-Medicaid patients; and opposing proposed legislation which would require hospitals to grant clinical psychologists medical staff privileges;
- determined that the SMS should continue to seek uniform procedural standards and requirements for all organizations using medical review to approve or deny health insurance benefits for medical care;
- adopted position statements recommended by the Task Force on AIDS which state: "the SMS Task Force on AIDS is in favor of broadening the statutory definition of health care worker to include emergency medical technicians, fire fighters, police officers, and good Samaritans for the current Wisconsin statute pertaining to significant exposure," and "the Task Force on AIDS of the SMS recommends statutory change permitting court-ordered, involuntary phlebotomy or obtaining of other body fluids for the purpose of HIV testing. All current statutory safeguards pertaining to HIV testing in the event of a significant exposure would apply;" and,
- gave final approval to joint proposals relating to health care cost containment initiatives.❑

Family physician. Located only 45 minutes from Minneapolis/St Paul, the residents of Baldwin are proud of their community for good reason. It boasts progressive businesses, a healthy retail district, accredited educational programs, and unlimited recreational activities! One additional family physician is needed to join this well-established practice; currently, a physician's assistant and four family physicians provide care for this community. Contact: Loriese A. Stoll, Ramsey Clinic, 640 Jackson St, St Paul, MN 55101; ph collect 612-221-3067. 3-4/91;6/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; ph 906-563-9243 or office 906-563-9255. 3-4/91

Minnesota communities seek family physicians. Private practice opportunities in attractive settings offer guarantees plus incentives, benefits, and hospital support. Locate your practice in Minneapolis, Richfield, Hopkins, Eden Prairie, Wayzata, Mound, Montgomery, Monticello, Lakefield, Litchfield, Springfield, or St James. Contact: Jerry Hess, Abbott Northwestern Hospitals, 800 East 28th St, Minneapolis, MN 55407; ph 1-800-248-4921. 3-5/91

Family practice opportunity as partner, and eventually to assume a well-established practice with flexibility and potential, and opportunity for surgery and OB if desired. Cooperative backup coverage available. Resort community with a number of industries, centrally located between Chicago, Milwaukee, and Madison. Modern 90-bed hospital. Contact: Glenn A. Smiley, MD, Delavan, WI 53115; ph 414-728-3441. 3-5/91

Opportunity for BC/BE family physician to join well-established physician in Christ-centered family practice. Newer offices located adjacent to hospital. A 1991 FP resident graduate would be welcome. Please contact Thomas R. Jensen, MD, 8800 West Lincoln Ave, West Allis, WI 53227; ph 414-321-7373. 3-4/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

West Bend, Wisconsin.. Seeking full-time and part-time emergency physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided, benefit package, and incentive bonus plan available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p3/91

Lake Winnebago, Wisconsin area. Seeking director, full-time and part-time emergency physicians for low volume 60-bed hospital. Attractive compensation, full malpractice insurance coverage and benefit package available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 in Michigan 1-800-632-3496. p3/91

Emergency physician, Milwaukee. Excellent opportunity for BC/BP emergency or otherwise qualified physician to join a stable, well-established, board-certified fee-for-service group staffing a 560-bed tertiary care teaching hospital's ED. 35,000 visits annually. Excellent specialty back-up. Peak double coverage on a daily basis. Salary starts at $130,000 per year for 40-hour work week, plus paid malpractice coverage and four weeks paid vacation/CME in first year. Exceptional benefits including paid vacation that grows to 12 weeks per year. Equitable partnership available. Send CV to I. Gailans, MD, FACEP, 5000 W. Chambers St, Milwaukee, WI 53210; ph 414-447-2171. p3-4/91

Family practice opportunity, Black Hills of South Dakota. An exceptional opportunity awaits for the right individual to join a progressive multi-specialty group practice located in the heart of the Black Hills of South Dakota. In addition to a very competitive compensation/benefit package, we offer a terrific call coverage schedule. Due to substantial economic development in our area, we are looking for this additional family practice physician. Contact: Darrel Riddle, Administrator, Black Hills Medical Center, 71 Charles St, Deadwood, SD 57732. 3-4/91

Experienced BC diagnostic radiologist available for supplementary or adjunctive imaging in or near the Milwaukee area. Willing to focus on a subspecialty service model, or to subcontract to meet a specific volume need of a group or facility. Amount of time, schedule and financial arrangements negotiable. Contact: Radiology, 1545 West Spruce Ct, Milwaukee, WI 53217-1128; ph 414-351-4034. 3-4/91

Choose between...several excellent familly practice opportunities in Illinois, Wisconsin, Arizona, and Maryland. Solo and group positions available with guaranteed salaries and competitive benefit packages. To discuss these positions in confidence, please call 1-800-969-7715. Dan Jones, Gielow/Laske Associates, Inc, 306 North Milwaukee St, Milwaukee, WI 53202. 3/91

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SEND TO: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Physicians Exchange

Continued

Orthopaedic surgeon, Black Hills of South Dakota. Outstanding opportunity to assume an established orthopaedic practice with a progressive multi-specialty group in the beautiful Black Hills of South Dakota. Modern clinic facility adjacent to an accredited, acute-care hospital and in the heart of a community experiencing substantital economic development. Attractive compensation/benefit package including paid professional liability insurance. Direct inquiries to D. Riddle, Administrator, Black Hills Medical Center, PC, 71 Charles St, Deadwood, SD 57732; ph 605-578-2364. 3-4/91

Antigo, Wisconsin. Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p3/91

Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

Non-invasive cardiologist. Four-physician, single-specialty cardiology group has an immediate opening for a BE/BC non-invasive cardiologist. Echo, doppler, holter, and treadmill are established in-clinic. Full invasive and surgical programs are established. The practice serves a large and expanding regional referral area in mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, PC, Attn: N. Polzin, 4701 Towne Center Rd, Suite 201, Saginaw, MI 48604. 3-5/91

Kewaunee, Wisconsin. Seeking part-time emergency physicians for low volume facility located 1/2 hour east of Green Bay. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 South Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p3/91

Medford, Wisconsin. Seeking director, full-time, and part-time emergency physicians for moderate volume facility located in northern Wisconsin. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p3/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

Chicago. Seeking full-time and part-time emergency physicians for new contract in metro Chicago Area. 200-bed hospital with annual volume of 8,000. Require emergency medicine or primary care training and experience. Excellent compensation, malpractice insurance provided, benefits available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p3/91

Mason City, Iowa. Seeking director, full-time and part-time physicians for low volume 75-bed hospital emergency department. Great opportunity to assist to develop "state of the art" quality assurance and educational programs. Excellent compensation, paid malpractice insurance and full benefit package to full-time staff. Contact Emergency Consultants, Inc, 2240 South Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p3/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 2-6/91

Emergency medical opportunity, Eau Claire, Wisconsin. Excellent opportunity to join a three-person private contract group. Twelve hour shifts. 17,000 annual visits. Competitive hourly rate with full comprehensive benefits. For further information please contact: Krista P. Greiner, Health Care Consultant, 2075 W. Big Beaver, Ste. 600, Troy, MI 48084; ph 313-649-2010. 2-4/91

ASSOCIATE DIRECTOR. The Appleton Family Practice Residency seeks a board-certified residency-trained family physician to join a well-established 18-resident program with an innovative competency-based curriculum. Affiliated with the University of Wisconsin Medical School, we are a community-based program intent on mutual growth of residents and faculty. Responsibilities include teaching, patient care, administration, and research. Appleton is a rapidly growing community with excellent schools in the heart of economically stable northeast Wisconsin–a great place to live and raise a family. Send CV or contact John Allhiser, MD, Program Director, Appleton Family Health Center, 229 South Morrison St, Appleton, WI 54911; ph 414-832-2789. 3-4/91

Family practice opportunity on the shores of beautiful Lake Michigan. The Two Rivers Clinic, Ltd., an 11-physician multi-specialty group is seeking BC/BE physician to join four family practice associates. Exceptional quality of life and outstanding recreational area for family. New facility within walking distance of hospital and nursing home. Excellent income potential. Send CV or contact Jack Gospodarek, Executive Director, 2219 Garfield Street, Two Rivers, Wisconsin collect 414-739-2281.

Two Rivers Clinic, Ltd.
2219 Garfield St., Two Rivers, WI 54241
1-3/91

Beloit Clinic, SC, an expanding 45-physician, multi-specialty group in southern Wisconsin college town, in southern Wisconsin college town, is seeking an internist, a pulmonologist, a rheumatologist, an OB/GYN, an ophthalmologist, a general (vascular) surgeon, and a plastic surgeon. Guaranteed salary with incentive, plus excellent fringe benefits. Send CV to James F. Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 1-3/91

Physicians Exchange

Continued

Urgent Care. Seeking BC/BE MD for 36 MD multi-specialty group on Lake Michigan in southeastern Wisconsin. Prefer specialty training in FP, IM, EM, surgery. Partnership possible within 18 months. State-of-the-art facility and equipment. Competitive compensation package negotiated. Beautiful setting. Abundance of recreational cultural activities. Contact: Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. p2-4/91

Urologist. Beautiful southern Wisconsin. BC/BE urologist to join 60-member multi-specialty clinic adjacent to 250-bed hospital. Community of 55,000 with excellent lifestyle. Good benefits and salary guarantee with full partnership after one year. Send CV to: Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St., Janesville, WI 53545. p2-7/91

Dermatologist, psychiatrist, allergist, internal medicine, family practice. A progressive, 126-bed, two-hospital system is seeking the above specialties to establish practices in the Iron Mountain area of Michigan's upper peninsula. Must be BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, C02 laser, and a fully-staffed special diagnostic department. Contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; ph 906-779-4500. 2-3/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Beautiful southern Wisconsin. Riverview Clinic, a 60-member multi-specialty clinic in Janesville, is seeking a third general surgeon. Clinic is adjacent to a modern, well-equipped hospital and has three primary care satellites in neighboring communities. Janesville, a city of 53,000, is centrally located between Madison and Milwaukee and close to Chicago. Excellent benefit package and salary guarantee first year with a full partnership thereafter. Send CV to Ronald Karzel, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 2-5/91

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BC/BE general internist (with or without subspecialty interest) to join a busy and expanding four (4) physician internist group in Oshkosh, Wisconsin. Guaranteed salary and production bonus. Excellent benefits and income potential. Send CV to Dept 630 in care of the Journal. 12/90;1-3/91

Family practice. Crystal Falls, in Central Southern Upper Peninsula of Michigan, is seeking a BE/BC family practice physician. The physician will have the option of joining an existing practice or setting up a hospital-sponsored practice. Service area of 8,000. Contact H. B. Purdy, CEO, Crystal Falls Community Hospital, Michigan Ave, & Third St, Crystal Falls, MI 49920, or phone; office 906-875-4144 or home 906-875-4145. 1-3/91

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

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Physicians Exchange

Continued

Internal medicine and infectious disease. Multi-specialty group seeking BC/BE general internist and infectious disease specialist to join 19-member department (5 general internists and 14 subspecialists including one infectious disease specialist). Clinic is physically attached to a 206-bed hospital. Two state universities and private liberal arts college enhance the cultural life of the community (population is approximately 100,000) and, with Minnesota's lakes country just a half-hour drive away, outdoor activities abound. Competitive salary, excellent fringe benefits package and malpractice paid. Contact: Dr John Hicks, Director, Recruiting Division, 1702 South University Drive, Fargo, ND 58103; ph 701-280-3338 or 701-280-8520. 11-12/90;1-4/91

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full-time staff physician. Approximately 10,000 annual visits. Compensation to be negotiated. Pleasant area in which to live, near Devil's Lake and the Baraboo Hills. Also, Madison nearby. Contact: Thomas Warwick, Executive vice President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; 608-356-5561, ext 492. 11tfn/89

Family practice physician wanted to join solo practitioner in a very progressive suburb of Green Bay, Wisconsin. Clinic is equipped with lab and x-ray facilities. Located near large recreational area. Send CV or contact M. J. Falk, MD, 2353 Ridge Rd, Green Bay, WI 54304; ph 414-494-9685. p11-12/90;1-4/91

Anesthesiologist needed for a two-week medical missionary tour. To be part of an orthopaedic surgical team at Esperanca Hospital in Santarem, Brazil, from August 11-24, 1991. For information contact W. W. Schaefer, MD at 414-452-5320. 2-3/91

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Medical Meetings-Continuing Medical Education

April 21-23, 1991: "21st Annual Meeting of the Wisconsin Association for Perinatal Care, Holiday Inn-West, Madison, WI. For more information contact Kim Hallock, WAPC Statewide Office, 1010 Mound St, Madison, WI 53715; ph 608-267-6060. 2-3/91

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1991-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1991 - April 18-20: Milwaukee
Wyndham Hotel
1992 - April 23-25: Milwaukee
1993 - April 15-17: La Crosse
Convention Center, Radisson
1994 - April 14-16: Milwaukee

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday; the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

AMA

June 23-27, 1991: Annual AMA House of Delegates, Chicago.
December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.

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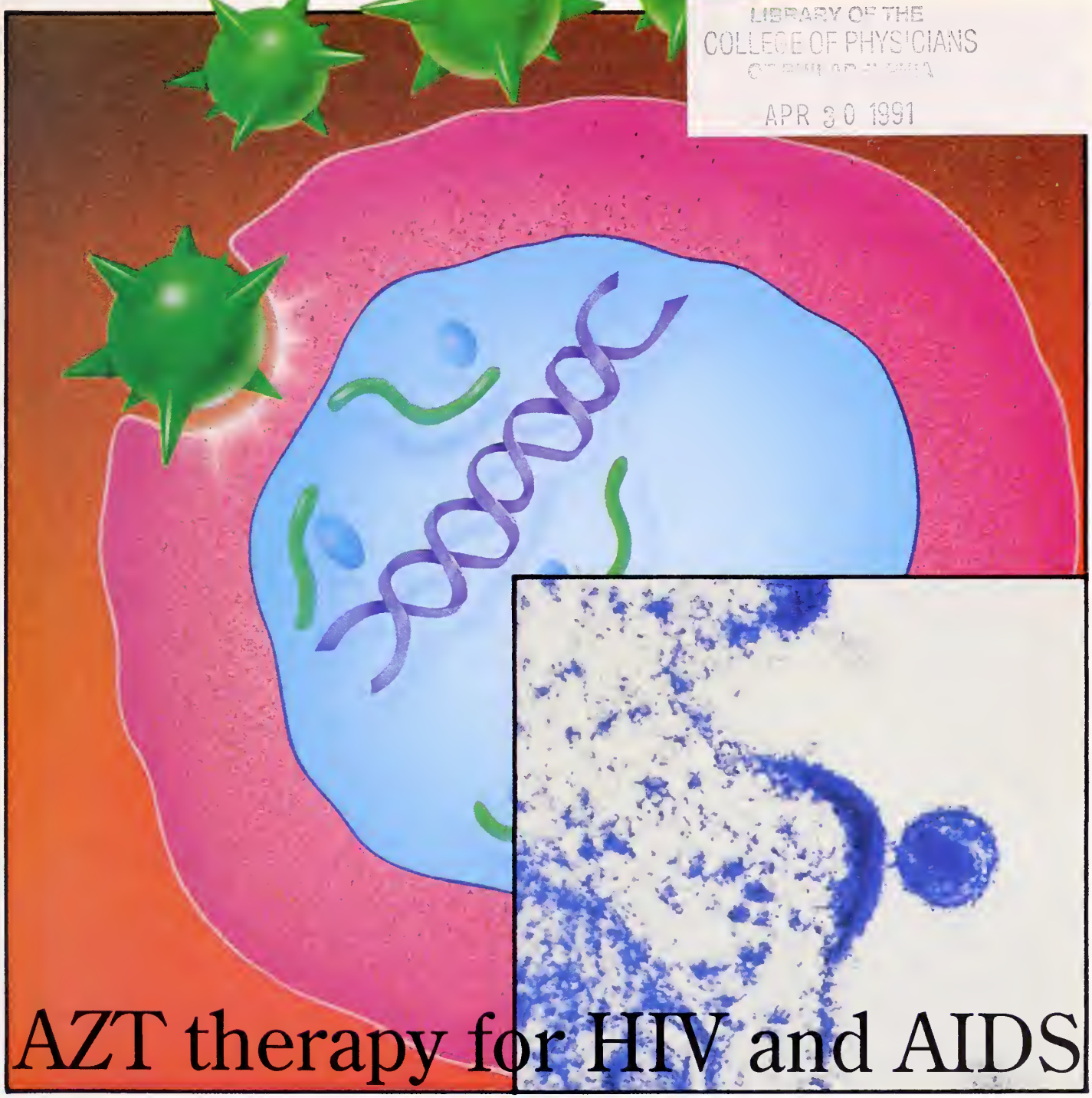

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Contents

April 1991 Vol. 90 No. 4

Opinions

147 *President's page*: The difficulty of measuring quality in health care
by Roger L. von Heimburg, MD, Green Bay
150 *Secretary's report*: The secret that so few have heard
by Thomas L. Adams, CAE, Madison
Letters
155 Reflections on war
by Peter C. Joosse, MD, West Bend
155 In agreement
by Elizabeth Allen Steffen, MD, Racine
155 The time has come to form a union
by J.S. Mayersak, MD, Merrill
156 Uniquely American
by Vinoo Cameron, MD, Athens
157 Basic trauma life support
by Dean Stueland, MD, Marshfield
157 Comments on mammography
by William B.A.J. Bauer, MD, Ladysmith
158 *Special*: Vital organ transplants and mutual obligations
by Odin W. Anderson, PhD, Madison

Scientific

161 Long-term zidovudine therapy in patients with AIDS and symptomatic and asymptomatic HIV infection
by Steven Ebert; Keith Gockel, MD; Sheldon Horowitz, MD; Patricia Weber, RN; Bennett Vogelman, MD; and Frank Graziano, MD, Madison
165 Prosthesis-induced synovitis simulating villondular synovitis
by Linda A. Karl, MD; and Walter R. Sundstrom, MD, Madison
169 Laparoscopic treatment of recurrent small bowel obstruction
by Paul D. Silva, MD; and Thomas H. Cogbill, MD, La Crosse
170 Pheumocystis carinii pneumonia following corticosteroid therapy for giant cell arteritis
by Hulon E. Crayton, MD; and Walter R. Sundstrom, MD, Madison

Socioeconomic

173 Health issues in the state budget
174 President Bush addresses liability reform
176 *Public Health*: Smoking and education in Wisconsin
by Michael Soref, PhD; Patrick L. Remington, MD; and Dennis Anderson, Madison
178 Wisconsin Supreme Court changes certified medical record statute
178 Patients Compensation Fund supports anesthesiology classification change
178 User fees suggested for National Practitioner Data Bank

Organizational

181 SMS activities: 1990 in review
187 Fort Crawford Medical Museum opens May 1
187 SMS helps obtain release of OMB funds
188 Physician briefs
188 SMS clarifies definition of medical malpractice payment relative to the National Practitioner Data Bank
189 County society news
189 SMS allowed to participate in physician demonstration project
190 Highlights of the 1990 SMS membership survey
190 SMS to physicians: question RBRVS software packages
191 Medical records alert: beware of unauthorized release without consent
191 Obituaries

Our cover: The illustration is of a human immunodeficiency virus binding to a CD4 cell (T-cell); the photograph is of an HIV "budding" out of an infected T-cell. Courtesy of the American Academy of Family Physicians, under a grant from the Burroughs Wellcome Co.

Wisconsin Medical Journal

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's Page

The difficulty of measuring quality in health care

In March, three business and industry benefit managers came to the Brown County Medical Society meeting to inform us about the Green Bay Health Initiative (GBHI), which is slated to begin soon. With this plan, data from all of our insurance claims for GBHI patients will be routed to a central office and analyzed before being paid. There is also a questionnaire that the patient completes after a health care encounter, which is also turned into the central office. The GBHI proponents hope that with this data they will soon know where to obtain the greatest value in health care in Green Bay–value being, as defined in the equation, low cost and high quality. When I asked how quality would be determined from the limited information available, no answer was forthcoming. This same data gathering endeavor is proceeding with different sponsors in several other cities in the state, including Madison.

The prevailing wisdom is that if one wants to measure quality of medical care, it is necessary to begin with determining severity of illness. Measuring severity of illness is not easy to do. Two systems that attempt to do this are MedisGroups of MediQual Systems, and Computerized Severity Index (CSI) of Health Systems International, both of which rely on detailed medical record abstraction. (Apache II, Acute Physiology and Chronic Health Evaluation, reviews medical records to measure severity, too, but also measures imminent risk of death for ICU patients.) CSI differs from MedisGroups in that it is a disease-specific system that assesses the severity of individual diseases. Medical records review is expensive and questions are arising as to whether the cost is justifiable. Pennsylvania was the first state to require collection of severity information on all hospitalizations. Pennsylvania has 300 hospitals now reporting data to the state Health Care Cost Containment Council (HCCCC), and the director of HCCCC believes that MedisGroups is a "good quality assurance tool," but the results are mixed. The Hospital of the University of Pennsylvania, in Philadelphia, found that the MedisGroups system has not helped it make any improvements in patient care, despite an investment of $350,000. Pennsylvania is not the only state doing this on a statewide basis; Iowa has begun requiring all hospitals with 100 beds or more to collect severity data.

There are other systems that attempt to measure severity of illness, but they use only computerized discharge data and not the medical record: Acuity Index Method, from Iameter in California; Coded Disease Staging-Equel, from SysteMetrics/McGraw Hill; and Patient Management Categories, of Pittsburgh Research Institute. These latter three groups may flag possible health care delivery problems with their data gathering, but most agree that in no way can they begin to measure quality of care.

Roger L. von Heimburg, MD

Associated with my work on the Office of Health Care Information Board of Directors, I sometimes hear business representatives say that they hope to gain information regarding quality of care from hospital discharge data collected by the OHCI. This data is gathered only from the standard UB 82 billing forms, and I warn them

Continued on page 148

Continued from preceding page
against trying to read measures of quality from that limited data.

Quality of medical care is difficult to define and even more difficult to measure. I have told the GBHI representatives that they probably will be measuring only cost and not quality. The folks running the GBHI will have to decide whether this is worth the $300,000 per year (of health care dollars) they will spend to gather the data. More information regarding charges from physicians' offices will be available to all, from the OHCI, beginning in 1992, as mandated by statute in 1988.

The desperation of business and industry in trying to control their rising health care costs is apparent. The development of practice parameters, which is proceeding apace, will help with this control but this will take time. Eliminating, or at least minimizing, the government shortfalls in Medicare and Medicaid payments will also help, and industry is aware of this, but the political process takes time, too.

This is my final editorial as your Society president, and as I write it I cannot help but look back over the accomplishments of the past year. It has been positve and productive, and one of our more important undertakings is the establishment of the SMS Task Force on Quality Assessment and Implementation of Practice Parameters. The task force will focus specifically on determining the best ways to measure quality of health care, but what is significant is that it will be *physicians* making that determination, and not insurers, industry leaders, so-called consumer advocates or government officials.

I began my presidency last April with a challenge to the membership, so it is fitting that I end it in the same way. Let us make a commitment to address the issues of cost and quality through our State Medical Society and in our daily practices: keeping, for instance, the cost-benefit ratio in mind when using new technology. The call for quality assurance is loud; our challenge is to answer.❑

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Secretary's report

The secret that so few have heard

SHAKESPEARE HAD MACBETH MOURN, on the death of the queen, "Life ... is a tale told by an idiot, full of sound and fury, signifying nothing," and there are times in association work when I can almost agree. The medical profession is so often misunderstood, misrepresented, misused, misgoverned, and misjudged that there are days when I listen to the "sound and fury" and shake my head, wondering about the meaning of our work at the SMS. Then something happens that muffles the fury, lifts the fog, and brings the meaning into sharp focus–crisp and clear, like the air on a bright spring Wisconsin morning.

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One such event was my reading of the nominations for the 1991 SMS Physician-Citizen of the Year award. This was the first year the Society opened the nominations to the public, and the number of nominations received increased more than 10 fold. But the simple volume is not the impressive part. What struck me, what overwhelmed me, was your patients' intimate outpouring of gratitude, respect, and genuine love for you, their physicians. I was moved. More than once I learned, or was reminded of, an important truth.

House calls, contrary to popular opinion, are not historic artifacts. There was the woman who had an appointment for her two small children, both very ill, on a day that was struck by a vicious winter storm. Two hours before her appointment, her family physician appeared at her door. He did not want her to take the children out in such bad weather. Then there was the elderly woman who was, for all practical purposes, trapped in her home by a flood. Her physician braved the waters to make his house call and treat his patient. A good many of you are making house calls, not because the weather is bad, but simply because you know that your patients' ability to come to you is impaired.

The image of the 15-year-old boy who, having no father in the home, talks to his doctor about everything from basketball to girls remains with me long after reading his mother's letter. His mother is grateful beyond expression for the physician who has taken more than a medical interest in her child, who has earned her son's trust, and who is providing a positive male role model for her young man. She nominated her doctor as a way of saying thanks.

Life at the nursing home and senior citizen center of one small community is enhanced by the physician who brings in his woodworking equipment for the elderly to use, and then serenades them with his banjo.

Thomas L. Adams, CAE

Life in another small town is enriched by the doctor who travels more than 100 miles each week to provide them their only health care. Another doctor serves on the volunteer fire department, and another spearheaded the building of a public library. There are countless physicians serving without compensation as youth group leaders, anti-drug abuse educators, and members of school boards, rescue squads, historical societies, environmental groups, and philanthropic organizations–to name only a few. The range of your service to your community stretches from your neighbors to fellow humans half a world away; from delivering groceries to shut-ins to raising funds to buy vaccines for the children of Third World nations.

This stack of nominations was awash in acts of personal charity and generosity: bills for medical services

Continued on page 152

AIM HIGH

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AIR FORCE

Continued from page 150
that simply never were sent; sample medications dispensed to patients who could not afford to buy their prescriptions; clothing, outgrown by the physicians' own children, quietly passed on to the families of less fortunate patients; and bright new toys delivered to fill otherwise empty Christmas mornings.

Perhaps the most moving nominations were those recounting moments of warmth and compassion. The stories range from physicians who listen respectfully when their patients express their fears to those who help families struggle through those first hideous moments after the death of a loved one. And they were as unembarrassed as they were personal: "I was so sick that I prayed to die, but my doctor wouldn't let me give up," "He always listens to me and understands," "She's so gentle and kind," "He came to our child's funeral and stood with us," "He sat up and waited through the night with me," "She held me while I cried."

Regardless of who takes home the actual award, all the nominees should consider themselves winners (listed below) for the trust, respect, and love their patients hold for them is far greater reward and far greater praise than we could ever offer. In fact, all of medicine should take pride in these nominations, for they undoubtedly represent only a fraction of those who are worthy. Congratulations.

Here, then, is our meaning. Here is our cause. Here is the secret that so few have heard, and even fewer understand: despite all the criticism, litigation, pragmatism, and regulation, the act of healing is still, at its essence, an act of love. Deeper than buyer and seller, provider and consumer, or physician and patient, medicine is a human-to-human interaction that requires and inspires that which is most noble in us. Artists occasionally arouse this sort of devotion, so do some religious leaders, but I know of no other profession, no other group of people, whose work elicits such passion.

The public, the press, the Legislature, so-called consumer advocates, the insurance industry, business, the legal profession, and Congress: all the critics and reformers of medicine–some self-serving and some misguided–fade in comparison. Put next to the praise of your patients, their sound and fury really does signify nothing. More importantly, the meaning, purpose, and value of our work at the SMS becomes clear. My resolve is deepened and my vigor renewed, and I hear Macbeth once more: "Lay on, Macduff, and damned be him that first cries, 'Hold, enough!'"

Nominees for Physician-Citizen of the Year 1991

Gary B. Adamski, MD
Francisco G. Aguilar, MD
Piero (Peter) Antuono, MD
Leonardo Aponte, MD
John A. Austin, MD
Raymond G. Bachhuber, MD
Vance La Mar Baker, MD
William H. Bartlett, MD
Irvin M. Becker, MD
Thomas R. Berentsen, MD
Paul F. Biere, MD
Roman Bilak, MD
Phillips T. Bland, MD
Richard J. Boxer, MD
Thomas Carter, MD
Richard K. Chambers, MD
Blaine W. Claypool, MD
John A. Cragg, MD
James L. Craig, MD
John R. Culver, MD
Anthony P. Dalton, MD
Richard A. Damon, MD
Edwin L Downing, MD
Peter L. Eichman, MD
Timothy T. Flaherty, MD
Henry A. Folb, MD
Kevin J. Fullin, MD
Harold B. Garner, MD
Robert E. Gehringer, Jr, MD
Kenneth I. Gold, MD
Bruce Gordon, MD
Ronald G. Gritt, MD
Terry L. Hankey, MD
Gregory J. Harrington, MD
George V. Hering, MD
John K. Hoyer, MD
Ralph F. Hudson, MD
Melvin F. Huth, MD
Robert W. Johnson, DO
Eugene R. Jonas, MD
Cathryn I. Kaiser, MD
K. Paul Katayama, MD
W. Joseph Kellner, MD
Kenneth R. Kidd, MD
Thomas M. Kidder, MD
Bruce L. Klink, DO
Christopher G. Koeppl, MD
Frederick C. Kriss, MD
Loren Leshan, MD
Larry A. Lindesmith, MD
Franklin Loo, MD
Enrique W. Luy, MD
Raul Mateo, MD
Johan A. Mathison, MD
Thomas G. McCall, MD
John P. Mullooly, MD
Robert E. Myers, MD
David L. Nelson, MD
Clarence G. Novatny, MD
Richard S. Ostenso, MD
Kent L. Partain, MD
Robert (Zorba) M. Paster, MD
John U. Peters, MD
Mitchell H. Pincus, MD
George M. Pope, MD
Marion E. Pruitt, MD
Curtis D. Radford, MD
N. Hans Rechsteiner, MD
Marcia J.S. Richards, MD
Harold K. Riches, DO
John D. Riesch, MD
Barry L. Rogers, MD
Stephen R. Rudisill, MD
William E. Scheckler, MD
Clemens S. Schmidt, MD
Louis S. Seno, Jr, MD
Michael Sergi, MD
Robert J. Smick, DO
Warren G. Smirl, MD
K. Kwang Soo, MD
Cory D. Spencer, MD
Elizabeth A. Steffen, MD
Charles L. Steidinger, MD
Arthur C. Taylor, MD
Alvin C. Theiler, MD
Joseph M. Tobin, MD
Frank H. Urban, MD
Sridhar V. Vasudevan, MD
Marvin Wagner, MD
Fred H. Walbrun, MD
Marwood E. Wegner, MD
James E. White, MD
Roger L. von Heimburg, MD ❑

THERAPY THAT MAY BE AS SILENT AS HYPERTENSION ITSELF

VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

FOR MANY HYPERTENSIVE PATIENTS
ONCE-A-DAY

VASOTEC®
(ENALAPRIL MALEATE | MSD)

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VASOTEC®
(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema*: Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus; limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include intrauterine growth retardation, prematurity, patent ductus arteriosus, fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

Precautions: *General*: *Impaired Renal Function*: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously if at all with VASOTEC. (See *Drug Interactions*.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients: *Angioedema*: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: *Hypotension—Patients on Diuretic Therapy*: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC® (Enalapril Maleate, MSD) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy: *Pregnancy Category D*: See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality: In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.)

Clinical Laboratory Test Findings: *Serum Electrolytes*: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(824)

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Letters
Reflections on war

TO THE EDITOR: I am pleased to see strong feelings expressed by MDs relating to social issues beyond medicine and economics. War and our nation's involvement touches us all, and understandably may elicit more passion than reason, but both are worthy of a forum.

The Gulf War still strikes me as indefensible. I say this acknowledging that the loss of lives may have been no different had sanctions continued – with more Kuwaits dead and tortured, more Iraqi civilians starved and victims of their despotic leadership. I acknowledge the coalition military performed very well, professionally, and honorably. I acknowledge that Saddam Hussien with his narcisstic and messianic personality structure was a threat to global security if allowed to build up his military might.

All that said, the foreign policy of the United States, Soviet Union, and their allies, throughout the cold war enabled and encouraged that build up. Nations not propped up by outside forces eventually rid themselves of despots. Change fomented from within builds esteem and pride. Change dictated from without builds hostile dependency.

There is a strong case to be made for a new world order. It begins with ending military hardware sales and arms races. It requires worldwide economic sanctions to deal with despots who do not respond to their peoples' needs or attempt to deflect unrest by refocussing on external bad guys. It requires all peoples having homelands and homes. It requires proactive governments – and we have a long way to go.

–Peter C. Joosse, MD
West Bend ❑

In agreement

TO THE EDITOR: I wanted to comment on Dr Vinoo Cameron's letter to the *Wisconsin Medical Journal* concerning the Physician-Citizen of the Year award. I could not agree with him more. With more than 7,000 physicians in the state of Wisconsin, there is no way to have nominations for a Physician-Citizen of the Year without politics and pressure for certain physicians. I agree with Dr Cameron and suggest the award die a quiet death, and one award given to "all physicians who service our patients quietly, courageously, and compassionately without seeking public limelight."

–Elizabeth Allen Steffen, MD
Racine ❑

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

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The time has come to form a union

TO THE EDITOR: A physician can only sit in constant amazement as Medicare continues to balance the health care budget of the United States on the backs of the physicians. All negotiations between the Health Care Financing Administration and organized medicine have proven to be nothing more than a sincere exercise in futility.

Throughout this constant assault on the physician, the costs of running a practice have continued to rise. Organized medicine, at least as far as the AMA and SMS are concerned, has done little to obtain any type of representation or negotiating position with regards to these dictates of the government.

It is becoming more apparent, even to those physicians who are conservative, that eventually some form of withholding services will be neces-

Continued on next page

Continued from preceding page
sary to obtain any type of adequate representation with the government. At the present time, such withholding of services could be interpreted as a violation of anti-trust law. Even more evident than the inappropriate treatment of the medical community by the government is the outstanding necessity for consideration of the SMS to form a union with its protection under the labor relations act. As members of such a union, the physicians in Wisconsin could, at the appropriate time, selectively withhold services to gain a better bargaining position with the government.

As the circumstances stand now, the physicians of Wisconsin, as well as the physicians of the United States, have absolutely no bargaining position, and absolutely no consideration is shown to the physician by either the Federal government or state government. Although this withholding of services is a distasteful concept to the majority of physicians, the total destruction of individuals rights of physicians is also one that is quite abhorrent and which should not be tolerated.

Some solution has to be arrived at with regard to the destruction of our freedoms and rights. Unfortunately, it appears that the formation of a union may be the only methodology to protect oneself in today's current environment. No other segment of society currently has their prices, their working conditions being dictated to them and "big brother" constantly watching over them.

This type of unnecessary, unjust and unconstitutional regulation by the government has to be protested. I see no other way, at the present time, to obtain effective methods of protesting with the protection afforded to members than that under the labor relations act. The time for consideration of formation of a medical union has arrived, unfortunately, much sooner than most of us had anticipated.

–J. S. Mayersak, MD
Merrill ❑

Uniquely American

To the editor: The Persian Gulf war crisis proved once again that we Americans are a unique people with a unique country, and this calls for a little reflection on our part as physicians. We hear a lot of voices, both public and political, calling for the abandonment of our uniquely American health care system and for the adoption of a Canadian system, a British type system, or an Australian system. I disagree entirely. National or socialized health systems are simply inconsistent with our way of life. Let me give you a few examples.

As a young intern at Christian Medical College in India, I picked up a beggar from the streets with severe gastroenteritis and carried his alive carcass on my bicycle to the local government hospital. I was laughed at by the physician, and the patient was thrown out the door because the doctor thought he was hopeless. There was no professional body to turn to for help.

I remember a time when, under their socialized system, Bristish patients complained about the waiting lists, low quality of care, and lack of choice, but had no professional body to turn to; they had to complain to some local bureaucrat in the district.

Last year, here in Wisconsin, a young farmer asked if I could, as a physician, give him a reference to the local politicians so that he could get a green card and stay and farm in the states. It turns out that his kids had come of age and needed social security numbers to get driver's licenses. This man was from Canada and he had come here illegally because in the Canadian system he was told what crops he could grow and how much.

In recent issues of the *Wisconsin Medical Journal,* some physicians have written to complain about Dr Roger von Heimburg's noble efforts as SMS president to inspire us to live up to our humanitarian obligations, and one wrote to ask SMS Secretary-General Manager Thomas Adams to apologize for an editorial he had written about his genuine concerns for the Americans in the Persian Gulf war. The criticism of this leadership has caused me to wonder what our profession and our Society have become.

As physicians, we should have a certain degree of professionalism, which includes humanitarianism, and our State Medical Society should reflect that trait. The purpose of the SMS is to lead us and inspire the noblest goals of our profession: the advocacy of our patients. Our American system of health care has developed some very serious flaws; are we, as professionals, going to lead in addressing them, or are we going to join the crowds? Are we going to take the lead in improving our uniquely American system or are we going to stand by while others transform it into something else, something less worthy? It is up to us. As physicians we must join hands with our Society, forget our petty needs and greed, and take the lead–for the sake of America.

–Vinoo Cameron, MD
Athens ❑

Basic trauma life support

TO THE EDITOR: I would like to take this opportunity to inform the physicians of the state of Wisconsin of the Basic Trauma Life Support. This is additional training being received by many of our EMTs in Wisconsin.

The Basic Trauma Life Support (BTLS) was developed by the Alabama Emergency Medicine Physicians as a pre-hospital care method consistent with Advanced Trauma Life Support within the hospital.

BTLS training has been ongoing in Wisconsin for more than 2 years with generous support from the Department of Transportation. It teaches basic and intermediate level EMTs to promptly identify and appropriately treat the approximately 5% of trauma victims who have suffered significant trauma such that they need early transportation to definitive hospital care.

BTLS anticipates a close working relationship between the pre-hospital service and its medical director. In addition, it stresses early recognition and transport of these victims. EMTs who are trained in this method may appropriately elect to transport patients early before there has been complete "packaging" of the patient. Specifically, if life threatening problems are noticed in the early or primary evaluation, the patient will be stabilized and transported promptly. In situations such as this, the pre-hospital crew will not obtain a full set of vital signs but base the recognition on problems related to the pulse, respiratory rate, level of consciousness or evidence of significant injuries.

It is paramount for physicians involved with pre-hospital care in Wisconsin to be aware of this training. As noted above, medical control is crucial in the training and direction. In addition, as emergency medical technicians adopt these skills, it is important for physicians to be supportive, tolerant and to continue with appropriate feedback.

The steering committee responsible for oversight of the BTLS training includes physicians, trainers and practitioners. If you have any comments, please forward them to myself or Karen Teske-Osborne, the executive director of the Wisconsin Chapter of Emergency Physicians which is serving as a clearinghouse for BTLS in Wisconsin.

–Dean Stueland, MD
BTLS medical director
Marshfield ❑

Comments on mammography

TO THE EDITOR: Mammography is coming into its own. More women are accepting it as an important guide to diagnosis of cancer of the breast. The technology of mammography has greatly improved. Less exposure to radiation is required with the newer x-ray machines. But the medical profession cannot afford to be satisfied to rest on its laurels.

Much needs to be done to make mammography more available. Prices of mammography have been reduced, but not in all locations. The medical profession must strive to reduce the cost throughout the states. To begin with, all medical insurance companies should include mammography costs in their policies. Ironically, the costs of mammography are not included in the AMA Medicare Supplement Insurance. Certainly, we, as physicians, should start the ball rolling by insisting that mammography be included in an insurance policy endorsed by the American Medical Association as an example to all medical insurance companies.

Much also needs to be done to make mammography more popular. Widely advertising its value can help; but person to person advertising is still the best way to get across the message. Herein lies a hurdle to overcome.

"I wish my husband had to go through this." "This is worse than having a baby." I have heard these comments and others from women who have gone through mammography. Such comments do not encourage women to have a mammogram as often as they should.

The breast is a very sensitive organ. Squeezing it tightly, as is done in mammography, appears essential to develop clear exposure of each area of the breast. When I recall the painful experiences of patients with breast abscesses, or a blow to the breast, I can understand their complaints of mammography compression.

Mammography could save even more women and should be an annual test, at least for women over 50 years of age. One of the aims of the medical profession should be to make mammography more comfortable and less costly for all women.

–William B.A.J. Bauer
Ladysmith ❑

Special

Vital organ transplants and mutual obligations

Mutual obligations are the core of a functioning society. Never before have law and custom been faced with the moral problem of the rising expectation that human beings dead or alive should donate a vital organ to a person who needs a replacement in order to continue to live. This expectation appears to be going beyond a voluntary act on the part of the donor, but an expectation because of organ shortages, that consent should be presumed unless a possible donor says"no." The decision to donate becomes one of volunteering to say "no" rather than volunteering to say "yes." The would-be donor is put on the defensive.

In this rationalistic age, it is not seemly to establish a position on an issue because of repugnance, emotions have no validity, only pure logic bereft of gut feelings. Gaylin first brought this out for me in an article in 1974 (Willard Gaylin "Harvesting the Dead" *Harper*, September 1974).

Gaylin observes that the maintenance of live but brain dead cadavers is justified to prolong the lives of people who need the organs. "And yet, he writes, after all the benefits are outlined, with the life-saving potential clear, the humanitarian purposes obvious, the technology ready, the motives pure, and the material costs justified–how are we to reconcile our emotions?...where in this debit-credit ledger of limbs and livers and kidneys and costs are we to weigh and enter the repugnance generated by the entire philanthropic endeavor?"

To legalize presumed consent is tantamount to ordering that people give up ownership of their own bodies.

My philosophical-theological stand then is that individuals should accept their bodies as they are as far as vital organs are concerned. I stress vital organs because they are necessary for life itself, and intruding somebody else's vital organ and a public policy which mandates this kind of intrusion erodes the integrity of the body one was born with, and places an unwarranted demand and stress on the populations as a whole and the support networks which are already overtaxed by long-term care and the elderly. We need to learn to live with our fate within those limits, and spare those who are healthy from giving up their rights to their own vitality.

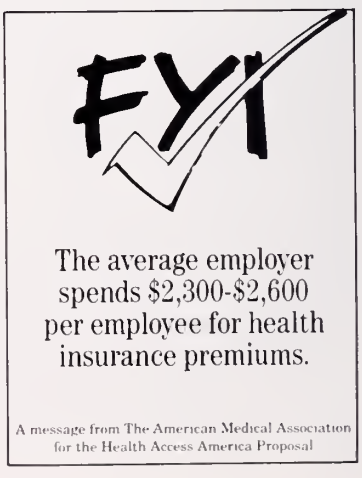
I discount financial cost for with a shifting of our priorities we as a society can afford it. We have a standard of affluence that can buy all material things, including human organs. What we can overload is the capacity of our informal social support networks to handle the many demands made on it for long-term care. Much of this support is not purchasable in the market, but is usually supplied by spouses, next of kin, and close friends.

A vivid example of overloading was reported in *Newsweek* Aug 29, 1983. There is a very energetic organ coordinator based in Pittsburgh and coordinating that city and San Antonio, by telephone, helicopters, and ambulances. As reported by *Newsweek*. "For Donald Denny, 48, it was a routine day's work. So far, this year has been even busier than last when he and his associate, Brian Broznick, 30, traveled 77,000 miles to obtain 102 kidneys, 80 livers, 22 hearts, and 3 sets of hearts and lungs for transplantation." Denny is so eager to fulfill his mission that he calls those who refuse to donate an organ "shirkers," a forecast of what the social atmosphere might be if presumed consent is mandated.

Helmut Thielicke (1978), professor of systematic theology, at the University of Hamburg, in Germany, poses the question: "Is there something about man that dare not be changed (by medical intervention)–something in his very nature that dare not be violated if he is to remain human?" He answers: "What is man? Thus a tension arises between that which is <u>not</u> under our control, the fundamental meaning and purpose of human existence, and that which <u>is</u> under our control, namely, the marvelous ministration of sophisticated medicine. The problem being that, by preserving a man only in part medicine may actually be depriving him of, and thereby violating, the very meaning and purpose of this life. When this tension amounts to high levels of intensity, it begins to blur the line of demarcation between healing and blasphemy." Human beings do not seem to be capable of controlling their own inventions.

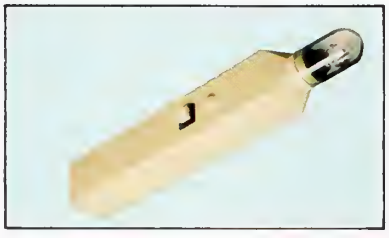
Are we content to stop at organ transplants? Probably not, but there will be social consequences out of our control because of unbridled demands of the individual on the group. We will ration transplants and decisions will have to be made as to who is worthy of a transplant and who is considered a shirker if shortages continue.

–Odin W. Anderson, PhD
Madison ❑



That was then . . .

this is the future!



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Marilyn Marquardt
Head Nurse, Riverview Family Birthplace (LDRP)
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Long-term zidovudine therapy in patients with AIDS and symptomatic and asymptomatic HIV infection

Steven Ebert; Keith Gockel, MD; Sheldon Horowitz, MD; Patricia Weber, RN; Bennett Vogelman, MD; and Frank Graziano, MD, Madison

Zidovudine is the only anti-retroviral drug approved by the FDA for treatment of HIV infection. We have examined the clinical and laboratory efficacy of this drug for 4 years in a cohort of HIV-infected patients from Wisconsin. Overall, we have found that individuals with AIDS will have at least 1 year of symptom reduction while on the drug. Those with asymptomatic HIV infection tolerate the drug and none have progressed to AIDS in the 4 years of study. Zidovudine is an important component in the treatment of HIV infection. *Wis Med J* 1991;90(4):161-165.

INFECTION WITH THE HUMAN immunodeficiency virus (HIV) over time causes a chronic and progressive depletion of the immune response.[1-4] This depletion creates an immune deficiency that leads to the opportunistic infections and cancer characteristic of the acquired immunodeficiency syndrome (AIDS). Although HIV does not usually cause clinically apparent symptoms in the infected individual until several years after infection[5] (and hence the majority of persons currently infected are asymptomatic), the progression to AIDS may be inevitable in untreated individuals. From the time of diagnosis of an AIDS defining infection or malignancy, the 3-year mortality rate is greater than 90%.[6,7]

Azidothymidine (zidovudine, Retrovir, also called AZT) is a nucleoside analogue that inhibits the in vitro replication of HIV.[8] The chemical benefit and toxicity of zidovudine (1200 mg per dose) in AIDS and symptomatic HIV infection were first demonstrated in a Phase II placebo-controlled trial.[9,10] This study demonstrated a significant reduction in the mortality and frequency and severity of opportunistic infection in those who received the drug and led to FDA approval of the agent for AIDS and the AIDS-related complex.

At the University of Wisconsin, we have been using zidovudine in individuals with HIV infection since 1986. In this report, we present our long-term (4-year) experience with this agent in a cohort of 45 individuals with asymptomatic and symptomatic HIV infection and AIDS. In this period of treatment we have not only evaluated clinical efficacy and toxicity of zidovudine, but we have also evaluated its effect upon laboratory parameters including T helper cell, beta-2 microglobulin, and P-24 antigen (virus) levels.

Patients and methods

Patient population. The number of individuals in this treatment cohort was 45. All were found to have positive HIV ELISA and Western blot tests at their initial visit to our clinic. Both men and non-pregnant women (41 men, four women) with an age range of 21 to 55 years were in this cohort of patients. Thirty-three of the patients were gay or bisexual, seven were IV drug abusers, one was a prostitute, one was a hemophiliac, one was the spouse of a hemophiliac positive for HIV infection, and two had no known source for HIV infection. Of the 45 patient cohort, 11 had an AIDS-defining infection or cancer, 13 had a symptomatic HIV infection, and 21 had an asymptomatic HIV infection. The 24 patients with AIDS or symptomatic HIV infection met the package insert criteria for institution of zidovudine therapy. The 21 asymptomatic patients had to meet at least two of the following criteria to be given the drug:

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Weber, Ebert, and Drs Gockel, Horowitz, Vogelman, and Graziano are with the University of Wisconsin Hospital and Clinics in Madison. This paper was presented in part at the American Academy of Allergy and Clinical Immunology National Meeting, 1989, San Antonio, TX. Address reprints to: Frank Graziano, MD, Department of Medicine, J5/220 Clinical Science Center, 600 Highland Ave, Madison, WI 53792. Copyright 1991 by the State Medical Society of Wisconsin.

Continued from preceding page

- T helper cell (CD4 cell) count of less than 400 cells/mm^3 (nl in our laboratory 400-1100 cells/mm^3);
- rapidly declining CD4 cell count (a drop of 200 CD4 cells at each of two consecutive measurements);
- beta-2 microglobulin level of greater than 4 (Nl 1.0 - 2.0 mg/L); and
- presence of P-24 antigenemia.

All asymptomatic HIV-infected individuals gave informed consent before starting zidovudine.

Patients who met the criteria stated above and agreed to take zidovudine were entered consecutively into our study. The data presented in this report represents the time from January 1986 to April 1990.

Treatment regimen. All 45 patients initially received 1200 mg (200 mg every 4 hours) of zidovudine by mouth daily. All patients were followed for clinical side effects and laboratory toxicity of zidovudine. Clinically significant side effects included asthenia, nausea, headache, dizziness, insomnia, and muscle aches or pain. Laboratory toxicity consisted primarily of anemia and granulocytopenia. For persons demonstrating significant clinical or laboratory toxicity, zidovudine was stopped for 1 week and then reinstituted at 600 mg (100 mg every 4 hours) per day. Zidovudine was discontinued permanently if the clinical or laboratory toxicity persistently recurred or failed to resolve.

Evaluation and follow-up. Before taking zidovudine, all patients underwent a baseline physical examination and laboratory testing. Routine laboratory testing included complete blood counts and evaluation of renal and hepatic function. Special laboratory testing consisted of CD4 cell counts (Orthodiagnostics Cytofluorograph System 2), beta-2 microglobulin and P-24 antigen levels. Patients with AIDS or symptomatic HIV infection were clinically evaluated monthly, or as needed according to the status of their disease or toxicity of the drug. Patients with asymptomatic HIV infection were clinically evaluated every 2 months, or as needed according the status of their disease or toxicity of the drug. All patients had routine laboratory testing every 2 weeks for the first 3 months, and then monthly thereafter unless toxicity occurred. Special laboratory testing was obtained every month for the first year, and every 3 months thereafter during the study.

Results

Clinical Response to zidovudine. The data that we report in this study has been collected through April of 1990. All patients starting zidovudine received a dose of 1200 mg day. Since April 1990, data has been presented to suggest that zidovudine can be given at 500 mg per day with good clinical effect and less toxicity.[11] Virtually all our patients since this time have received zidovudine at the reduced dosage.

The mean time (through April 1990) that individuals with an asymptomatic HIV infection (n = 21) were on zidovudine was 78 ± 32 weeks (range 24 to 124 weeks). During this time, two patients were lost to follow-up (after 6 months on the drug). Excluding these individuals, the mean time on the drug was 86 ± 24 weeks with (range of 52 to 124 weeks). During this time, no patients progressed to symptomatic HIV or AIDS. Since April 1990, of the 19 patients still evaluable, none have progressed to AIDS, and two now have symptomatic HIV infections (both stopped the drug due to toxicity before progression).

Of the 13 persons with symptomatic HIV infections, (through April 1990) the mean time on the drug was 60 ± 19 weeks (range of 28 to 96

Table 1.–Increase in T helper (CD4) cell count in response to zidovudine.*

	Mean ± SEM increase in absolute CD4 count at peak response (N)	Time to peak CD4 count mean ± SEM (months)	†Number of patients with CD4 increase number of CD4 cells/mm^3						
			50	100	150	200	300	400	NR
asymptomatic	172±20 (21)	3.0±0.49	2	4	7	4	2	-	2
symptomatic	201±38 (13)	3.5±0.75	1	1	2	6	1	-	2
AIDS	88±40 (11)	1.7±0.4	-	1	-	2	-	1	7

*Zidovudine dose given 1200 mg/day

†Shown is the number of patients in each group demonstrating an increase of CD4 cells at the level shown after instituting zidovudine. NR represents no increase or a decrease in CD4 cells after anti-retroviral therapy.

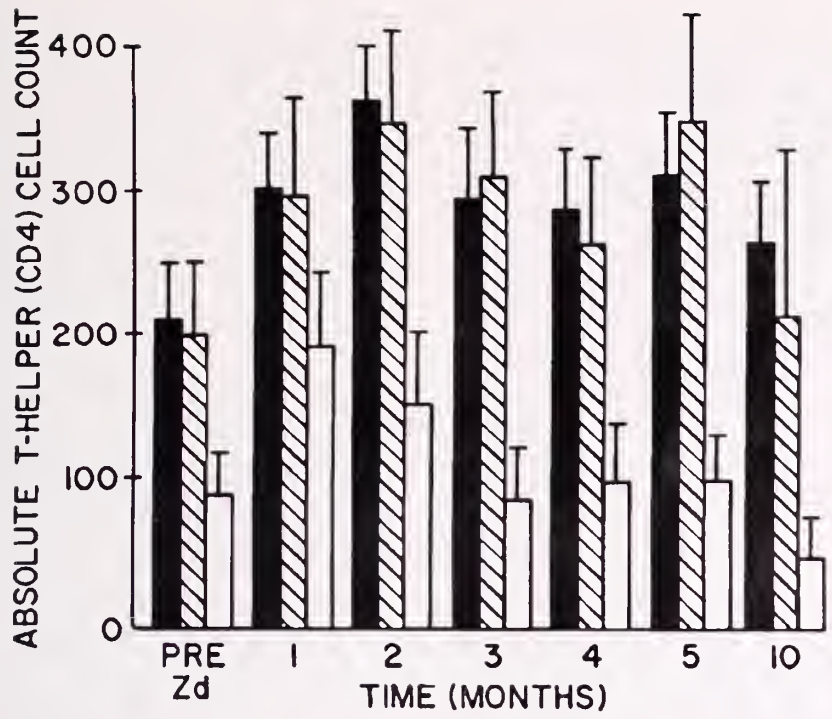

Fig 1.–The mean +/-SEM CD4 cell counts of 45 patients with HIV infection before and after institution of zidovudine. ■ HIV infected asymptomatic; ▨ HIV infected symptomatic; □ AIDS.

weeks). Two patients were lost to follow-up after 15 months on the drug. Of the 11 evaluable patients, three progressed on to AIDS while on zidovudine. Three other patients stopped the drug because of toxicity. Of these three latter patients, one has progressed to AIDS and the other two had increased symptoms and were placed on other anti-retroviral therapy. Five persons remain on zidovudine with a relatively stable course.

Of those with AIDS[11] (through April 1990), the mean time on zidovudine was 54 ± 44 weeks (range of 4 to 156 weeks). Clinically, nine of 11 patients had 56 ± 20 (SD) weeks with a decrease in symptoms and no opportunistic infections. From the start of the study, six have died from their disease, two stopped the drug because of toxicity, and three continued the drug. Since April 1990, the two who stopped the drug secondary to toxicity have died. Of the three who remained on the drug, one progressed to a second opportunistic infection and stopped anti-retroviral therapy, a second died, and one patient remains on the drug in reduced dosage.

Laboratory response. We have been able to follow comprehensively CD4 cell levels for a prolonged period of time in our HIV population receiving zidovudine. Figure 1 demonstrates that those persons with AIDS had a transient rise in CD4 counts which quickly returned to baseline or below. Patients with asymptomatic or symptomatic HIV infections, however, increased and maintained the CD4 cell level at least over the 10-month interval shown. Table 1 demonstrates the increase in absolute CD4 count measured at the peak response time after instituting anti-retroviral therapy. While 63% of patients with AIDS show no increase (or a decrease) in CD4 cell number after instituting zidovudine, 85-90% of those with asymptomatic or symptomatic HIV infections showed a increase in the CD4 count peaking at of mean of 3 to 3.5 months after starting the drug. Of the 19 evaluable asymptomatic patients, 65% have maintained their CD4 cell level above 200/mm.[3]

P-24 core antigen levels were also followed over time in our patient group. Seven of 11 individuals with AIDS had detectable levels of the P-24 core antigen in blood before starting zidovudine. Five of these seven had a decrease in the P-24 antigen blood concentration with zidovudine therapy. More crucial in this group, however, was the rise of the P-24 antigen while on zidovudine or after decreasing it because of toxicity. Patients with AIDS who had a rise in the P-24 level did poorly. In those individuals with symptomatic HIV, six of 13 started drug therapy with detectable P-24 antigen in the blood. Four of these patients showed a decrease in the level, three to below detectable levels. Only two of those with asymptomatic HIV infections had detectable P-24 antigen levels in their blood, and both responded to zidovudine therapy with the levels becoming undetectable with therapy and remaining so through the period of this follow-up. Figure 2 gives a representation of the profile of P-24 antigen levels over time in single patients from each group treated with zidovudine. Beta-2 microglobulin levels did not show changes over time with zidovudine treatment.

Toxicity of zidovudine. Of the clinical toxicities noted with zidovudine, nausea and asthenia were the major symptoms seen in our population. None of our 45 patients stopped zidovudine because of clinical toxicity. The major problems encountered in the laboratory with zidovudine were anemia and decreased neutrophil counts (Table 2). All patients with AIDS experienced laboratory toxicity, and this was the primary reason for stopping the drug in this group. Of the 10 who experienced anemia (Table 2), four were transfusion de-

Continued on next page

pendent. Reduced platelet counts and hepatic enzyme abnormalities were seen in these persons, but it was often difficult to ascertain if these abnormalities were secondary to drug or to the HIV disease itself. Two with symptomatic HIV infections were transfusion-dependent. In asymptomatic HIV-infected patients, anemia and neutropenia were observed (Table 2), but only one was transfusion-dependent and warranted discontinuation of the drug.

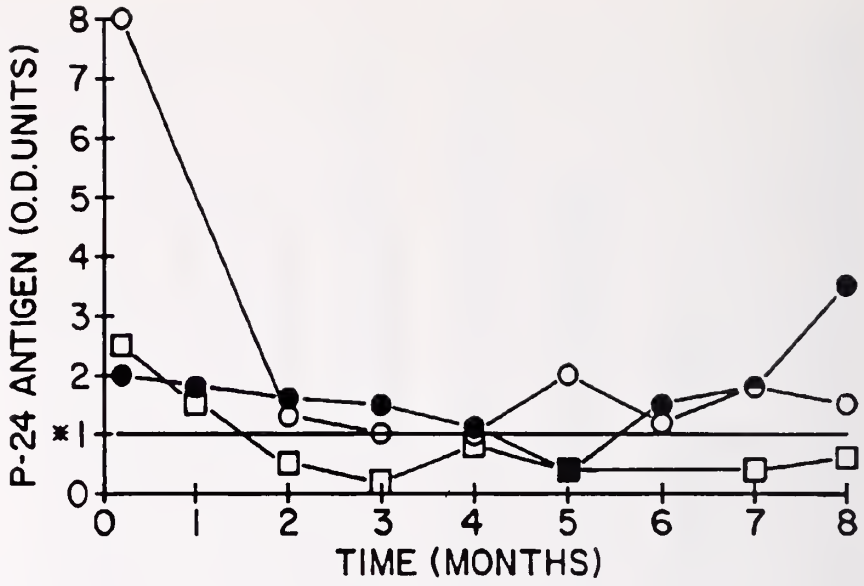

*Fig 2.–P-24 antigen concentration (in optical density units) over time in three HIV-infected patients. Patient with asymptomatic HIV infection □; patient with symptomatic HIV infection ○; patient with AIDS ●; The * indicates the 1 OD level. Serum readings for p-24 below this level were considered negative (below sensitivity of the test) and above were considered positive.*

Discussion

At this time zidovudine is the only anti-retroviral drug approved for HIV infection by the FDA. Placebo controlled studies[9,10] have demonstrated efficacy of zidovudine in persons with symptomatic HIV infections and AIDS at a dose level of 1200 mg/day. Long-term follow-up of the laboratory aspects of the study, however, have not been extensively examined. It was the purpose of our work to examine the clinical and laboratory effects of zidovudine (1200 mg/day) treatment in a cohort of patients with various stages HIV infection in Wisconsin.

While not a placebo-controlled study, we have followed our patients clinically and in the laboratory for up to 4 years. The major findings of our study are the following:

1) Persons with AIDS had at least 1 year of deceased symptoms and episodes opportunistic infections while on the drug. One patient has survived 4 years on zidovudine. In general, the laboratory parameters significant to HIV (CD4 count, beta-2 microglobulin, P-24 antigen) were unaffected except that the P-24 antigen level decreased in five of seven patients when the drug was started. Toxicity was greatest in this group and was the limiting factor in treatment;

2) Five of eleven evaluable patients with symptomatic HIV infections did not show progression to AIDS while on zidovudine. The three who stopped the drug because of toxicity have progressed in their disease; and

3) Of the asymptomatic group, none of 19 evaluable patients have progressed in HIV disease during the study. In the laboratory, CD4 cells have remained above 200/mm^3 in 65% of these individuals. Greater than 90% of the asymptomatic patients have been on the drug for at least 2 years. Toxicity to zidovudine (both clinical and laboratory) has not been a major factor in this group.

Recently, studies have demonstrated that reduced doses of zidovudine (500 mg or 300 mg for asymptomatic HIV infections and 600 mg for AIDS) are as successful in slowing the progression of HIV or decreasing symptoms or opportunistic infection in those individuals with AIDS.[11,12,13] The significantly less toxicity noted has made this type of regimen desirable. The first reports of these studies appeared in April 1990, and since that time virtually all of our patients requiring zidovudine have been tak-

Table 2.–Laboratory toxicity observed with zidovudine.

	Asymptomatic HIV infection (N=13)	Sypmtomatic HIV (N=11)	AIDS infection (N=21)
	Number of total with toxic effect.		
anemia	8	7	10
neutropenia	2	2	8
thrombocytopenia	0	0	4
hepatic enzyme abnormality	1	1	6

ing reduced doses of the drug. Since that time, one of our asymptomatic HIV-infected individuals progressed to AIDS after having stopped the drug because of toxicity. Although we have many more patients now on zidovudine, we have not as yet performed a detailed analysis of the clinical, laboratory and toxicity parameters as discussed above in those persons receiving reduced doses of zidovudine

References

1. Bowen DL, Lane HC, Fauci AS. Immunopathogenesis of the acquired immunodeficiency syndrome. *Ann Intern Med.* 1985;103:704-709.
2. Lang W, Anderson R, Perkins H, et al. *Pattern of CD-4 lymphocyte decline from HIV seroconversion to AIDS.* Presented at the Fourth International Conference on AIDS, Stockholm, June 12-16, 1988. Abstract.
3. Fauci AS, Macher AM, Longo DL, et al. Acquired immunodeficiency syndrome: Epidemiologic, clinical, immunologic, and therapeutic considerations. *Ann Intern Med.* 1984;100:92-106.
4. Ho DD, Pomerantz RJ, Kaplan JC. Pathogenesis of infection with human immunodeficiency virus. *N Engl J Med.* 1987;317:278-286.
5. Moss AR. Predicting who will progress to AIDS: at least four laboratory predictors available. *Br Med J.* 1988;297:1067-1068.
6. Bacchetti P, Osmond D, Chaisson RE, et al. Survival patterns of the first 500 patients with AIDS in San Francisco. *J Infect Dis.* 1988;157:1044-1047.
7. Rothenberg R, Woelfel M, Stoneburner R, et al. Survival with the acquired immunodeficiency syndrome: Experience with 5833 cases in New York City. *N Eng J Med.* 1987;317:1297-1302.
8. Mitsuya H, Weinhold KJ, Furman PA, et al. 3'-Azido-3'-deoxythy-midine (BW A509U): An antiviral agent that inhibits the infectivity and cytopathic effect of human T-lymphotropic virus type III/lymphadenopathy-associated virus in vitro. *Proc Natl Acad Sci USA.* 1985;82:7096-8100.
9. Fischl MA, Richman DD, Grieco MH, et al. The efficacy of azidothymidine (AZT) in the treatment of patients with AIDS and AIDS-related complex: A double-blind, placebo-controlled trial. *N Engl J Med.* 1987;317:185-191.
10. Richman DD, Fischl MA, Grieco MH, et al. The toxicity of azidothymidine (AZT) in the treatment of patients with AIDS and AIDS-related complex: A double-blind, placebo-controlled trial. *N Engl J Med.* 1987;317:192-197.
11. Valberding P, Logakos S, Koch M, et al. Zidovudine in asymptomatic human immunodeficiency virus infection. *N Engl J Med.* 1990;322:941-949.
12. Fischl M, Parker C, Pettinelli C, et al. A randomized controlled trial of a reduced dose of zidovudine in patients with the acquired immunodeficiency syndrome. *N Engl J Med.* 1990;323:1009-1014.
13. Collier A, Bozzette S, Coombs R, et al. A pilot study of low dose zidovudine in human immunodeficiency virus infection. *N Engl J Med.* 1990;323:1015-1021.❑

Prosthesis-induced synovitis simulating villondular synovitis

Linda A Karl, MD; and Walter R. Sundstrom, MD, Madison

Prosthetic arthroplasties are performed frequently in arthritic patients. The usual causes of prosthetic failures are loosening, infection, subluxation, or fracture. A 65-year-old man with total knee arthroplasty illustrates the complication of prosthetic synovitis developing 5 years after metal-polyethylene arthroplasty. Double contrast arthrography revealed nodular synovial filling defects. Arthrotomy and hematoxylin-and-eosin-stained histological sections of the synovium showed nonpigmented villonodular synovitis (VS). Giant cells and polyethylene particles were observed by polarized light within the synovium. *Wis Med J* 1991;90(4):165-167.

We observed a case in which the patient appeared to have clinical and histologic evidence of villonodular synovitis VS following a total knee arthroplasty. Particulate wear debris of the prosthesis were observed in the synovial inflammatory infiltrate, and giant cells contained particles of the foreign material. We suspect this synovial reaction was caused by particles from the prosthesis.[1] Particles resembling polyethylene seemed to stimulate the inflammatory process as previously observed by Mirra,[2] Crugnola,[3] and Kaufmann.[4] Recent reports have speculated on the pathogenesis of prosthetic or VS.[5,6,7] These speculations included reactive inflammation and benign neoplasia. Similarity of this reaction to the pathology of VS lends indirect support to the theory that VS may result from an inflammatory process.

Case Report

A 65-year-old male entered William S. Middleton Memorial VA Hospital complaining of pain and swelling of the right knee of 2 months' duration. The patient denied fever, chills, weight loss, periarticular erythema, or

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The patient denied fever, chills, weight loss, periarticular erythema, or trauma.

The patient had a 15-year history of degenerative joint disease of both knees. Five years previously, he had undergone a left knee total joint arthroplasty, followed 10 weeks later by a right knee geometric arthroplasty. The right knee procedure was complicated by a persistent varus deformity during the intra-operative fitting of the prosthesis, which required a thicker medial tibial plateau component. Seventeen days postoperatively, the right knee was manipulated under anesthesia because the patient had failed to gain adequate range of motion. The remainder of his recovery was uneventful.

The physical examination revealed an obese male. The head, neck, chest, cardiovascular system, and abdomen were unremarkable. The right knee extended to 5^0 and flexed to 120^0 with crepitation. Patellar motion was restricted. There was evidence of a synovial effusion manifested by a ballottable patella and loss of patellar sulci. One plus medial laxity was present at 30^0. There was a trace of lateral laxity. Genu varus deformity was present. The patient was tender to medial and lateral joint palpation. Examination of the left knee presented similar findings to the right, except there was no swelling and tenderness. The surgical scars over both knees were well healed.

Laboratory studies on admission revealed a normal complete blood count, differential, platelet count, and chemistry panel, except for a SGOT of 58 (normal, 7-40). Cultures of sero-

Fig. 1 – Double contrast arthrography showing hypertrophic synovial abnormality defects.

sanguinous synovial fluid from the right knee were negative.

Roentgenograms of the right knee showed soft tissue swelling and no evidence of a lucent interface between the methylmethacrylate and bone. Double contrast arthrography showed hypertrophic synovial abnormality characterized by multiple nodular filling defects (Fig 1). No contrast dye entered the interface between the prosthesis and bone.

The patient underwent arthrotomy, synovectomy, and lateral release of the patella. At surgery, the synovium was found to have a brownish hue and was studded with numerous nodular hypertrophic villi. Several 2-mm, round, pearly-white, loose bodies were found along with tibial marginal bony proliferation. The tibial polyethylene component was frayed, and a nearby small piece of loose cement was noted anteromedially. There was no loosening of either component.

The tissue was fixed and stained with hematoxylin and eosin. Light microscopic examination revealed thickened synovium and multiple villi (Fig 2). Giant cells with small empty clefts within the cytoplasm were abundant. The dense cellular infiltrate contained primarily histiocytes and lymphocytes. The vessels were normal, and there were areas of dense collagen deposition. There was very little hemosiderin pigmentation. Several metal fragments (small black bodies) were seen, with no surrounding inflammatory response.

The tissue was also examined with polarized and compensated polarized light. Multiple intracellular and extracellular particles appeared under polarized light. Most of these structures were rod-shaped and varied in length from 5 to 100 μm. These structures appeared in the corresponding clefts seen on light microscopy (Fig 3). A few cumulus-shaped empty spaces contained very small amounts of amorphous polarizing material adjacent to their margins (Fig 4). Some of these cloud-shaped empty spaces were surrounded by inflammatory mononuclear cells.

Discussion

Prosthetic joint replacement is a common surgical procedure resulting in reduction of pain and improvement in function. Following prosthetic replacement, joint pain may recur. Mechanical failure[6,8,9] of the prosthetic appliance or inflammation of the synovial membrane are conditions associated with these failures. Most clinicians are familiar with the causes of mechanical failure, migration, loosening, subluxation, dislocations and fracture, but few general physicians are aware that metal fragments, methylmethacrylate cement, polyethylene [1,10,11] or sialastic can induce prosthetic synovitis.[12]

Inflammatory synovitis produced by foreign material[13-16] and histologic findings in failed noninfected pros-

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thetic joints of the metal to polyethylene type have appeared in the literature.[2,4,12,17] Mirra[2] showed evidence of chronic inflammation (lymphocytes, histiocytes, giant cells and rod-like birefringent intracellular fibers) in the synovium of patients with noninfected failed prostheses. Ewald[18] and Tong[12] described giant cell synovitis as a complication of polyethylene shredding from patellar prostheses. Scanning electron microscopy of failed polyethylene prostheses show wear[18] and fusion defects in the polyethylene components. Docken reported a case of VS 12 years after placement of an acrylic femoral head prosthesis.[5] Vigorita[29] reported PVS-like lesions in the synovia removed during arthroplasties for rheumatoid arthritis, osteonecrosis, and degenerative joint disease prior to placement of prostheses. The histology in our case was similar to those reported by Mirra[2] We were struck by the similarity between the gross and microscopic appearance of the synovial tissue in our case and the arthrographic appearance of our case is identical to that described in VS.[9,20] We suspect that these incriminated particles were polyethylene because their shape resembled that of the rods described by Mirra.

Polyethylene induced inflammatory responses have been described in animal models.[10,21] Ridgon[10] and Escalas[21] implanted a solid and particulate forms in the muscles of New Zealand albino rabbits. Histologically, polyethylene particles gave a 3+ inflammatory response, and polyethylene blocks were associated with a minimal inflammatory response.

Recurrent hemarthroses in animal models can stimulate a VS-like lesion,[8,11,22,23] suggesting that the synovitis associated with hemophilia is similar to VS.[20] Our case and others in the literature suggest that there may be materials other than blood that can stimulate a VS-like lesion.

We cannot exclude the possibility of the spontaneous appearance of villonodular synovitis in our patient,

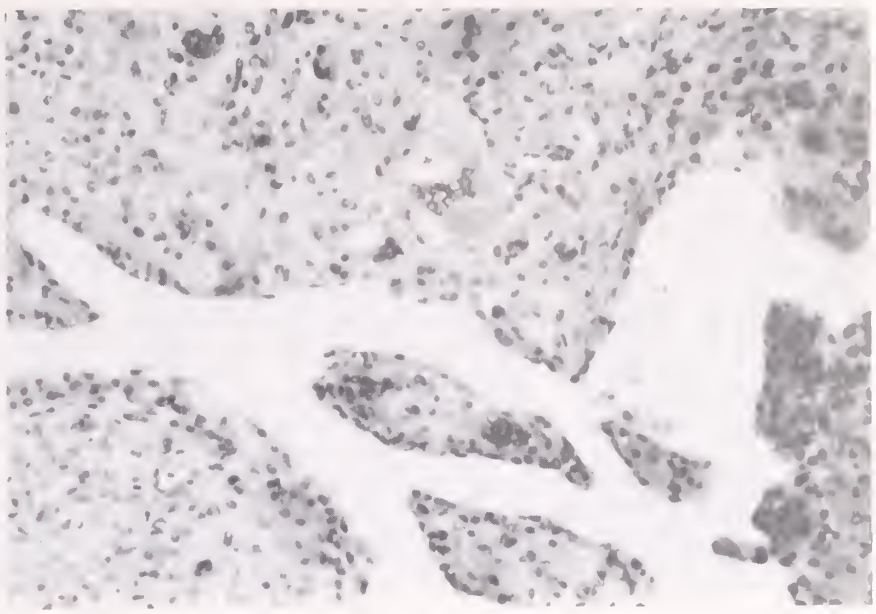

Fig. 2 – Light microscopic examination revealing thickened synovium, multiple villi, and giant cells.

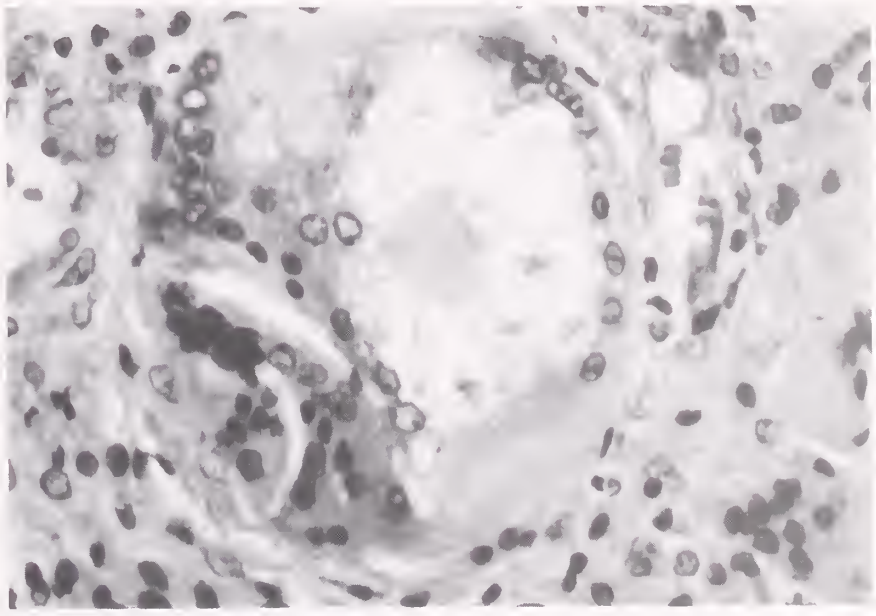

Fig. 3 – Light microscopy showing rod-shaped intracelluar and extracelluar particles.

but the rarity of villonodular synovitis (1.8/million/year)[6] and the normal appearance of the synovium 5 years earlier make this unlikely.

The complications of joint prosthetic surgery loosening, dislocation, fracture, infection or prosthetic synovitis are manifested by pain, decreased range of motion, and a decrease in function with or without signs of infection. These complaints often require x-rays, arthrograms, radionuclear scans and joint aspiration in an attempt to pinpoint the apparent cause of a painful joint following replacement arthroplasty. The majority of these patients will have loosening or infection as a cause of prosthetic fail-

Fig. 4 – Microscopy showing bi-refrigent particles seen in Fig. 3.

ure. There is a subset of patients, possibly 5% to 10%, however, that have post surgical pain without an apparent identifiable source of this pain. It is this subset of patients that may have prosthetic induced synovitis requiring revision arthroplasty. In these patients synovial fluid or membrane should be investigated for polyethylene or metal alloys.

In summary, we describe a case of synovitis of the knee occurring 5 years after a metal-polyethylene total knee arthroplasty. The synovitis was grossly, radiographically, and microscopically similar to villonodular synovitis or synovitis with giant cell reaction.

References

1. Rostoker W, Chao E, Galante J. The appearances of wear on polyethylene: A comparison of in vivo and in vitro wear surfaces. *J Biomed Mater Res.* 1978;12:317-335.
2. Mirra J, Amstutz H, Matos M, et al. The pathology of the joint tissues and its clinical relevance in prosthesis failure. *Clin Orthop.* 1976;177:221-240.
3. Crugnola A, Schillar A, Rodiw E. Polymeric debris in synovium after total joint replacement: Histological identification. *J Bone Joint Surg (AM).* 1977;59A:860-862.
4. Kaufman RL, Tong I, Beardmore T. Prosthetic synovitis clinical and histological characteristics. *J Rheum.* 1985;12:1066-1074.
5. Docken W. Pigmented villonodular synovitis: A review with illustrative case reports. *Semin Arthritis Rheum.* 1979;IX:1-22.
6. Myers B, Masi A, Feigenbaum S. Pigmented villonodular synovitis and tenosynovitis: A clinical epidemiologic study of 166 cases and literature review. *Medicine (Baltimore).* 1980;59:223-238.
7. Wa K, Ross P, Guise E. Pigmented villonodular synovitis: A clinical analysis of 24 cases. *Orthopedics.* 1980;3:751-758.
8. McCollum D, Musser A, Rhangos W. Experimental villonodular synovitis. *South Med J.* 1966;58:966-970.
9. Rein B, Bilodeau L, Johanson P. Arthrography and arteriography in pigmented villonodular synovitis of the knee. *AJR.* 1964;92:1322-1327.
10. Rigdon R. Plastics and inflammation. An in vivo experimental study. *J Biomed Mater Res.* 1974;8:97-117.
11. Singh R, Grewal D, Chakravarti R. Experimental production of pigmented villonodular synovitis in the knee and ankle joints of rhesus monkeys. *J Pathol.* 1969;98:137-142.
12. Tong I, Beardmore T, Kaufman R. Prosthetic synovitis: A consideration in painful prosthetic joints. *Arthritis Rheum.* 1981;24(S62).
13. Aptekar R, Davie J, Cattell H. Foreign body reaction to silicone rubber. *Clin Orthop.* 1974;98:231-232.
14. Christie A, Weinberger K, Dietrich M. Silicone lymphadenopathy and synovitis. *JAMA.* 1977;237:1463-1464.
15. Sugarman E, Stobie D, Quismorio F, et al. Plant thorn synovitis. *Arthritis Rheum.* 1977;20:1125-1128.
16. Worsing A, Engber W, Lange R. Reactive synovitis from particular silastic. *J Bone Joint Surg.* 1982;64-A:581-585.
17. Ewald F, Sledge C, Carson J, et al. Giant cell synovitis associated with failed polyethylene patellar replacements. *Clin Orthop.* 1976;115:213-219.
18. Walker PS, Bullough PG. The Effects of friction and wear in artificial joints. *Orthop Clin North Am.* 1973;4:275-293.
19. Vigorita VJ. Pigmented villonodular synovitis-like lesions in association with rare cases of rheumatoid arthritis, osteonecrosis, and advanced degenerative joint disease. Report of 5 cases. *Clin Orthop.* 1984;183:115-121.
20. Wolfe R, Giuliano V. Double contrast arthrography in the diagnosis of pigmented villonodular synovitis of the knee. *AJR.* 1970;110:793-799.
21. Escalas F, Galante J, Rostoker W. Biocompatibility of materials for total joint replacement. *J Biomed Mater Res.* 1976;10:175-195.
22. Volz R, Peltier L. Experimental production of pigmented villonodular synovitis in rabbits. *Surg Forum.* 1963;14:452-453.
23. Young J, Hudacek A. Experimental production of pigmented villonodular synovitis in dogs. *Am J Pathol.* 1954;30:799-811.❑

Laparoscopic treatment of recurrent small bowel obstruction

Paul D. Silva, MD; and Thomas H. Cogbill, MD, La Crosse

The treatment of recurrent small bowel obstruction due to postoperative adhesions has traditionally consisted of lysis at laparotomy. We report interval open laparoscopic lysis of adhesions to manage one patient. This technique was safely and effectively applied. Additional cases, however, will need to be analyzed to determine the applicability and indications for a laparoscopic approach to recurrent small bowel obstruction. *Wis Med J* 1991;90(4):169-170.

MECHANICAL SMALL BOWEL obstruction due to postoperative adhesions is not uncommon after intra-abdominal operations.[1-5] In patients with persistent obstruction or recurrent episodes, laparotomy with enterolysis has been recommended.[6] Many intra-abdominal procedures, however, are increasingly amenable to laparoscopic techniques.[7] We report interval open laparoscopic lysis of adhesions to treat recurrent mechanical small bowel obstruction.

Case report

A 40-year-old woman with recurrent small bowel obstruction was advised to undergo lysis of adhesions. Her surgical history included gastric bypass, drainage of subphrenic abscess, removal of ectopic pregnancy, myomectomy and resection of endometriosis, and small bowel resection for obstruction. She had recently been hospitalized twice within a 5-week period for partial small bowel obstruction with incomplete resolution of symptoms. She continued to experience colicky abdominal pain and nausea on a soft diet.

Contrast gastrointestinal radiographs demonstrated no intrinsic bowel lesions. A standard mechanical bowel prep was administered and laparoscopic lysis of adhesions was performed under general anesthesia. A 10 mm laparoscope with an operative port was inserted by open technique. Two secondary puncture sites were placed so that blunt probes could be manipulated to explore the bowel. Three loops of ileum were adherent to each other, the lower abdominal parietal peritoneum, and rectosigmoid colon. These adhesions were carefully divided by precise action of laparoscopic scissors and knife under direct vision. The bowel and peritoneal cavity were assiduously inspected before closure of the incisions.

The patient was discharged home 4 hours later. Repeat laparoscopy for infertility evaluation performed 2 months after the primary procedure demonstrated one loop of ileum that was adherent to the pelvic brim. An adhesive band was divided. The patient has had no further evidence of bowel obstruction 14 months after the procedure.

Comment

Initial management of acute mechanical small bowel obstruction due to postoperative adhesions consists of intravenous fluid replacement and gastrointestinal tube drainage. Resolution of the acute episode occurs in 80% of cases.[1,2] When symptoms persist or peritoneal signs are evident, laparotomy is mandatory. Laparoscopy is not appropriate in cases of acute small bowel obstruction with marked intestinal distension.

Recurrent small bowel obstruction may also require operative intervention.[6] Laparotomy with enterolysis has been the mainstay of treatment. Our experience indicates that open laparoscopic lysis of adhesions may be an effective alternative for selected cases of recurrent small bowel obstruction. Instruments analogous to those used at laparotomy can be applied laparoscopically including scissors, knives, and electrocautery.

The full length of small bowel can be examined using blunt probes. All surgical actions are performed under direct vision.

To our knowledge, this report documents the first case of open laparoscopic treatment of recurrent small bowel obstruction. Generalization of the value of this therapy should not be made as yet. Caution should be applied as further cases are performed since there are various steps in the procedure where failure to complete the treatment laparoscopically can be expected to occur in some cases. First, despite the use of open laparoscopy, it might be impossible to safely introduce the laparoscope into the peritoneal cavity if extensive adhesions are present. Second, perforation of the bowel may mandate laparotomy. Third, unexpected pathology might be encountered making bowel resection the optimal procedure. Finally, since probing of the interstices of the small bowel would not seem to be as complete a procedure as "running the bowel," cases may be encountered in which there is difficulty in identifying the site where extrinsic adhesions have occurred. To lessen the effect or possibility of these occurrences, the use of preoperative bowel x-rays, bowel preparation and open laparoscopy is recommended, as was done in the current case. Further cases and/or series will need

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to be reported to determine the relative success of this treatment in comparison to laparotomy with lysis of adhesions.

Small bowel obstruction due to postoperative adhesion formation after laparotomy is a relatively common surgical condition estimated to occur in 5% of cases.[5] The lowest estimate of its occurrence was stated in a study of 248 patients who underwent negative laparotomies for trauma.[8] Five patients (2%) developed postoperative small bowel obstruction secondary to adhesive disease. Surgical treatment of small bowel obstruction has generally required large midline incisions with prolonged hospitalization, and outpatient laparoscopic treatment holds the potential for a significant reduction in morbidity and cost for the patient.

References

1. Alvarez RD. Gastrointestinal complications in gynecologic surgery: A review for the general gynecologist. *Obstet Gynecol.* 1988;72:533-540.
2. Krebs HB, Goplerud DR. Mechanical intestinal obstruction in patients with gynecologic disease: A review of 368 patients. *Am J Obstet Gynecol.* 1987;157:577-583.
3. Stewart RM, Page CP, Brender J, et al. The incidence and risk of early postoperative small bowel obstruction. *Am J Surg.* 1987;154:643-647.
4. Tanphiphat C, Chittmittrapap S, Prasopsunti K. Adhesive small bowel obstruction. *Am J Surg.* 1987;154:283-287.
5. Jones PF, Munro A. Recurrent adhesive small bowel obstruction. *World J Surg.* 1985;9:868-875.
6. Jones RS; Sabiston DC Jr, Duke, JB, eds. Intestinal Obstruction. *Textbook of Surgery.* Philadelphia, PA: WB Saunders Company; 1986:905-914.
7. Silva PD. A laparoscopic approach can be applied to most cases of ectopic pregnancy. *Obstet Gynecol.* 1988;72:944-947.
8. Weigelt JA, Kingman RG. Complications of negative laparotomy for trauma. *Am J Surg.* 1988;156:544-547. ❑

Pheumocystis carinii pneumonia following corticosteroid therapy for giant cell arteritis

Hulon E. Crayton, MD; and Walter R. Sundstrom, MD, Madison

Pneumocystic carinii pneumonia (PCP) is a well-recognized complication of immunodeficiency disorders. PCP has been reported in patients with connective tissue diseases, but most were on cytotoxic drugs. We report a case of PCP occurring in a patient with giant cell arteritis who was receiving high dose prednisone. To our knowledge this complication has not been previously reported. *Wis Med J* 1991;90(4):170-171.

PNEUMOCYSTIS CARINII PNEUMONIA (PCP), characteristically occurs in patients with a variety of immunodeficiency disorders that include, Acquired Immunodeficiency Syndrome, agammaglobulinemia and malignancies, especially Hodgkins and non-Hodgkins lymphomas. Immunosuppressive drugs used in the treatment of malignancies, organ transplants and connective tissue disorders (CTDs) also increase the incidence of PCP.[1-3] PCP has been documented in patients with Wegener's granulomatosis, polyarteritis nodosa, vasculitis of unknown type, rheumatoid arthritis, SLE and polymyositis. It is unclear whether these patients were receiving cytotoxic drugs in addition to corticosteriods.[1,4,5] We report a case of PCP in a patient with giant cell arteritis (GCA) treated with prednisone alone, who had no other underlying risk factors.

Case Report

A 71-year-old man was in a state of good health when he developed progressive generalized scalp pain, jaw claudication, anorexia, malaise, chills and night sweats. During the 5 days prior to admission to the ophthalmology service, he complained of occasional dimming of vision in the left eye. He had a history of vascular headaches associated with visual symptoms, but these episodes were different from his usual migraines. He denied arthralgias, myalgias, and fever. A physical examination revealed a temperature of 97.7°F, BP

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116/78, pulse 80, respirations 20/min. A head examination was significant for prominent tender bilateral temporal arteries. The fundoscopic examination was negative. Examination of the peripheral vascular system was negative for bruits, and pulses were equal and symmetric. The results of the remainder of the physical examination were negative.

Pertinent findings of the laboratory examination showed a Westergren Sed Rate of 126 mm/hr, WBC 11.6 K/ul, hemoglobin (Hb) 12.2 g/dl, hematocrit (HCT) 36.5 ml/dl, platelets 613 k/ul. Electrolytes, blood urea nitrogen, creatinine, electrocardiogram (EKG), and chest x-ray film (CXR) were normal. A 3 cm left temporal artery biopsy was diagnostic of GCA.

He subsequently received 125mg IV bolus of methylprednisolone, followed by prednisone 20mg orally, four times daily. Over the next 24 hours, his symptoms markedly improved. At discharge, his Westergren Sed Rate was 90 mm/hr. He remained on prednisone 20mg orally, four times daily, for 10 days, followed by 20 mg orally, three times daily, for 12 days. After developing insomnia, dyspnea and subjective leg weakness, the prednisone was administered 50 mg every morning. The results of creatine phosphokinase, aldolase, and thyroid function tests remained normal. Within two weeks, his prednisone was decreased to 40 mg every day.

Several days later he developed progressive shortness of breath, dyspnea on exertion, and a dry cough. A physical examination showed a temperature 100°F, BP 96/60, pulse 94. His lungs revealed bibasilar rales and diffuse wheezes. The remainder of the results of the physical examination were negative. Pertinent laboratory data included a Hb 12 g/dl, HCT 35 mg/dl, WBC 8.5 K/ul, with 81% segs, 6% bands, 6% lymphs and a Westergren sed rate 125 mm/hr. Arterial blood gases on room air showed: pH 7.5, pCO_2 32 mm/Hg, pO_2 58 mm/Hg, with 92% saturation. The CXR showed diffuse interstitial changes, most prominent in the bases. Bronchoscopy and broncho-alveolar lavage (BAL) were positive for few Pneumocystis carinii cysts. Stains and cultures were negative for bacteria, fungi, and tuberculosis. He was treated with high IV doses of trimethoprin/sulfamethoxazole (TMP/SMX), and his respiratory status improved. Antibody to human immunodeficiency virus (HIV) was undetectable in the blood. He was discharged, on prednisone 25mg daily, in satisfactory condition.

Discussion

Pneumocystis carinii is a well recognized pathogen in pulmonary infections. In children, PCP has been documented in prematurity, malnutrition, and congenital immunodeficiency diseases.[2] Aggressive therapeutic regimens for organ transplants have increased the incidence of PCP pneumonia in both child and adult malignancies. Cases of PCP have been reported in CTDs such as SLE, rheumatoid arthritis, Wegener's granulomatosis, polyarteritis nodosa, and systemic vasculitis of unknown type. It is not clear, however, whether these patients were also managed with corticosteroids, chemotherapeutic regimens, or both.[1,4,5] Often, it is difficult to know how long into therapy complications developed. To our knowledge, PCP has not been reported in a patient with GCA. A Medline review covering 20 years of literature did not reveal a reported case of PCP in giant cell arteritis. PCP has been documented in patients with endogenous Cushings syndrome and appears to be related to a morning plasma cortisol level greater than 121 mg/dl.[6]

This case report shows the risk of PCP in a patient with GCA who received initial high doses of steroids. In addition, PCP developed approximately 5 weeks into therapy. It is possible that the high dose of steroids used in the initial phase of treatment, because of the patient's visual acuity history, may have influenced the development of PCP in this otherwise healthy man. GCA normally is responsive to conventional doses of corticosteroids. Conventional therapy uses prednisone 60 mg/d, initially, followed by a gradual reduction in the dose commensurate with the patient's clinical symptoms. We are not aware that doses greater than 60 mg/d have shown any benefit exceeding standard doses of corticosteroid; rather, they may induce complications altering the risk-benefit odds in favor of toxicity.

References

1. Walzer PD, Perl DP, Krugstad DJ, et al. Pneumocystis carinii pneumonia in the US: Epidemiologic, diagnostic, and clinical features. *Ann Intern Med.* 1974;80:83-93.
2. Burke BA, Good RA. Pneumocystis carinii infection. *Medicine.* 1973;52:23-51.
3. Bungo MW, Beetham WP. Pneumocystis carinii associated with polyarteritis and immunosuppressive therapy. *Arthritis Rheum.* 1977;20(5):1142-6.
4. Peters SG, Prakash UBS. Pneumocystis carinii pneumonia: Review of 53 cases. *Am J Med.* 1987;82:73-78.
5. Western KA, Perera DR, Schultz ME. Pentamidine Isethionate in the treatment of pneumocystis carinii pneumonia. *Ann Intern Med.* 1970;73:695-702.
6. Graham BS, Tucker WS. Opportunistic infections in endogenous Cushing's syndrome. *Ann Intern Med.* 1984;101:334-338. ❑

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Health issues in the state budget

THE 1991-1993 BIENNIAL BUDGET, as proposed by Gov Tommy Thompson, includes a number of important health-related provisions. Some of the key items of concern to physicians are highlighted below.

Medicaid reimbursement
Gov Thompson's 1991-1993 biennial budget calls for a phased-in increase in Medicaid reimbursements for obstetrics and pediatrics, but no across-the-board boost in Medicaid reimbursements for physician services. Details of the package include:

- increasing Medicaid reimbursements for obstetric services from the current 65% of average charges to 70% in July 1992 and 75% in January 1993.
- increasing Medicaid reimbursements for pediatric services from 60% of average charges to 65% in July 1991 and 70% on Jan 1, 1993.

Last year, the governor had vetoed legislation approved by the Legislature that would have increased obstetric and pediatric reimbursements under Medicaid to 75% of average charges on July 1, 1990.

For the 1991-1993 biennium, the governor did include a 3.5% increase in nursing home reimbursements under Medicaid for each year, and a 5.4% increase in 1992 and another 5.9% in 1993 for hospital services. An additional $5 million is targeted for Sinai Samaritan Hospital in Milwaukee in light of its role as the last inner-city hospital in Milwaukee. HMOs would receive a 5.5% increase each year of the biennium.

In light of the growing concerns about access to health care facing Medicaid recipients, and the relationship between access to care and equitable Medicaid reimbursements, the SMS will continue to push for reimbursements at 75% of average charges for obstetrics and pediatrics, effective July 1, 1991. A modest across-the-board increase for all physician services and allocation of additional funds to begin adjusting reimbursement for services that are particularly under-reimbursed will also be sought.

Medical liability
A provision to reinstate the $1 million cap on non-economic damage awards in medical malpractice actions is included in Gov Thompson's 1991-1993 biennial budget. The $1 million cap expired at the end of 1990, after intensive efforts by the SMS to lower the cap to $250,000 were blocked in the last legislative session.

The SMS will again press the Legislature to take action to limit increases in medical liability costs through adoption of a $250,000 cap on non-economic damage awards and the enactment of other reforms to the current tort system.

Small business health insurance
Gov Thompson has proposed an initiative to help small businesses provide health insurance to their employees. The proposal, outlined in the governor's budget message, would institute rate restrictions and renewal requirements on insurers covering businesses with 25 or fewer employees. The plan also calls for creation of a small employer insurance board that would develop a basic benefits health insurance policy to be marketed by private insurers.

The rate restrictions and renewal requirements in the governor's package are intended to stabilize insurance costs for small employers and provide protection from non-renewals based on reasons other than fraud, breach of contract or failure to pay premiums. The claims history of the employer would not be a justifiable basis for dropping coverage under the terms of the proposal. The governor's proposal is similar to reforms proposed in the health care cost containment initiative developed by the SMS, Wisconsin Manufacturers and Commerce, and the Wisconsin Hospital Association.

The proposed small employer insurance board would have responsibility for developing a basic benefits health insurance package and negotiating with health care providers for uniform and presumably discounted fees for services provided under the plan. Employers eligible for the plan would include those with 25 or fewer employees not offering health insurance within the previous 12 months. Employers would be required to contribute 75% of the

premium for individual coverage and 60% for a family plan.

While the SMS supports the concept of allowing insurers to market basic benefit plans, the only exemption in the governor's proposal from current mandates is for mental health and AODA services, leaving a package that is a far cry from a basic benefits plan. The idea of having a state board set provider reimbursement rates, while insurers set their own premium rates, is also a point of concern for the SMS. The same goal of creating low-cost, basic benefits health care coverage could be accomplished with far less administrative cost and burden by authorizing insurers to sell basic benefit plans which meet certain standards set by statute or administrative rule.

Physician loan assistance
The governor's budget would provide funding to expand the physician loan assistance program by eight slots. It would also modify the criteria for obtaining loan funds, including an additional criterion that the physician may not have practiced in the medical shortage area for more than 2 years before receiving funds. The SMS played a key role in the creation of this program and advocates its expansion; it is concerned, however, that this additional criterion would unfairly penalize physicians with educational debts who are currently practicing in medical shortage areas.

Injury prevention
The governor's budget would eliminate the current funding level of $308,200 per year for the relatively new injury prevention grant program. The SMS supported creation of the program.

Emergency medical services
While the EMS grant program would continue, funding of $1.1 million would come from transportation revenues rather than general purpose revenues under the governor's budget proposal. The SMS had supported creation of the program which, as originally proposed, would have been funded from transportation revenues because much of the demand placed on the EMS system is related to traffic accidents.

AIDS
The current AIDS drug reimbursement program would be funded at a level sufficient to continue the program's current 215 slots. State funding for the AIDS clinical trials research consortium would be eliminated; last year the consortium received $150,000 in state funds, characterized as one-time funding.

Physician licensure fees
Fees for physician license renewal, and for most professional licenses handled by the Department of Regulation and Licensing, would be adjusted to reflect the department's estimate of costs incurred to provide administrative and investigative resources for each profession. While some license fees would decline, physician fees would increase to $123 every 2 years (currently the license renewal is $82 every 2 years).

The budget bill (AB 91) is currently in the Joint Finance Committee. Debate on the budget, and reshaping of its various provisions, will continue until final passage at the end of June. Watch *Medigram* and *Capital Update* for timely updates, or for further information contact Terry Hottenroth or Mike Kirby in the SMS Division of Public Affairs at 1-800-362-9080 or (608) 257-6781.❑

President Bush addresses liability reform

The Bush administration has unveiled an initiative to reform state medical liability laws. The proposal calls for a cap on non-economic damage awards, prohibition of joint and several liability for non-economic damages, elimination of the collateral source rule which allows plaintiffs to recover twice for the same injury, and a requirement that lump-sum awards be replaced with structured payments.

While the proposal has ambitious goals, the mechanism by which the administration would encourage states to act is decidedly more modest. Under the terms of the plan, the Federal government would, beginning in 1995, create an $890 million incentive pool funded primarily by withholding from hospitals part of their annual increase in Medicare prospective payments, as well as from retaining 2% of the state Medicaid match for administrative expenses. States that adopt an unspecified number of reforms would receive enhanced Medicaid match rates and their hospitals would receive supplemental Medicare payments. The proposal was included as part of the president's fiscal year 1992 budget.❑

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Public health

Smoking and education in Wisconsin

Michael Soref, PhD; Patrick L. Remington, MD; and Dennis Anderson, Madison

THE PERCENTAGE OF ADULTS in the United States who smoke declined from 40% in 1965 to 29% by 1987.[1] Research has demonstrated, however, that this progress has not been shared equally across all socioeconomic groups.[2] In this report we assess the effect of one measure of socioeconomic status–educational attainment–on current and past smoking habits among Wisconsin adults.

We analyzed information on education and cigarette smoking from the Wisconsin Behavioral Risk Factor Surveys for the 3-year period from 1987-1989 (n = 3,889). These random digit-dialed telephone surveys are conducted throughout the year to assess the health practices of Wisconsin adults. Observations are weighted to adjust the sample to the estimated age and sex distribution of the population.

Respondents were asked if they had ever smoked at least 100 cigarettes and if they currently smoked. We calculated prevalences of current, former, and ever (includes current and former) smoking and the quit ratio (an index of cessation, defined as the ratio of former to ever smokers). The confidence intervals for those with less than high school education were 11% or less and for all other percentages reported were 7% or less.

Dr Soref is with the Center for Health Statistics and Anderson and Dr Remington are with the Chronic Disease Surveillance Unit, Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Address reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1 W Wilson St, PO Box 309, Madison, WI 53701-0309.
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Current smoking. In 1987-1989, 25% of Wisconsin adults smoked cigarettes. Current smoking rates varied by level of education in the younger age groups (Table). For example, among persons 18-34 years of age, 56% of those without a high school education smoked compared to only 19% of those with more than a high school education. In fact, among younger persons, smoking rates were directly related to the duration of education, with the lowest rates observed among persons with post graduate education (Figure). This variation by level of education was not found among persons 55 years of age and older.

Ever smoking. Among younger persons, those with less education are more likely to have ever smoked. For example, among persons 18-34 years of age, 73% of those without a high school education smoked at some time in their life, compared with only 37% of persons with more than high school education.

Quit ratios. Finally, younger persons with less education are less likely to have quit. For example, among persons 18-34 years of age who had ever smoked, only 23% of those without a high school education quit smoking, compared with 48% of persons with more than a high school education.

Comment

Current and past cigarette smoking rates are substantially higher among

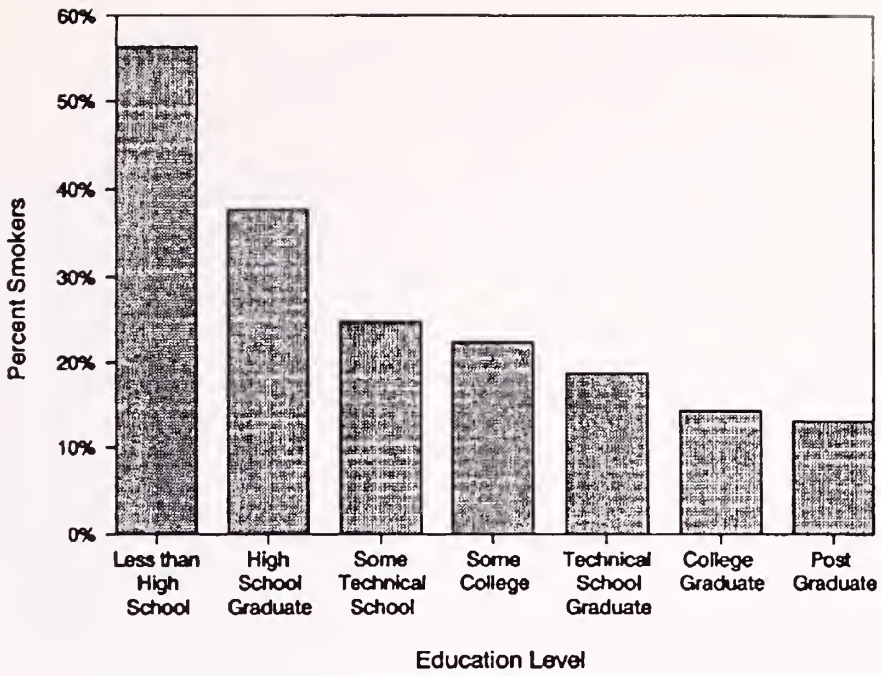
Cigarette smoking status, by age and education, in Wisconsin, 1987-1989.

Age group	Education < high school	high school	> high school
18-34			
current smoker	56%	38%	19%
former smoker	17%	15%	18%
ever smoker*	73%	53%	37%
quit ratio**	23%	28%	48%
35-54			
current smoker	50%	34%	22%
former smoker	26%	27%	32%
ever smoker	76%	62%	54%
quit ratio	34%	44%	59%
55+			
current smoker	13%	18%	16%
former smoker	31%	33%	36%
ever smoker	45%	51%	52%
quit ratio	70%	65%	69%

* Includes former and current smokers.
** Percent of ever smokers who have quit (fomer/ever).
Source: Wisconsin Behavioral Risk Factor Surveys.

less educated young adults in Wisconsin. In fact, of all personal characteristics, educational attainment is one of the most strongly correlated with smoking behavior (Figure).[2] Although it may influence smoking practices directly, education is also a proxy for other important socioeconomic factors, such as income, occupation, residence, or social networks.

Two phenomena are responsible for the high rates of smoking among the less educated. First, less educated adolescents are much more likely to begin smoking. For example, 73% of young adults who dropped out of high school started to smoke compared with only 37% of young adults who attended college. Second, less educated persons who smoke are less likely to quit. Again, only 23% of less educated young adults who smoked have quit compared with 48% of persons who have had some college education.



Fig–Smoking prevalence among persons 18-34 years of age, by education, in Wisconsin, 1987-1989.

These trends in smoking in Wisconsin appear similar to those observed at the national level. During the 1950s and early 1960s, smoking rates were similar across all education groups.[1] But between 1965 and 1987, the prevalence of smoking among college graduates declined by more than half, from 34% to 16%. In contrast, the prevalence among persons without a high school education (36%) did not decline.

Why are smoking rates higher today among the less educated? First, public health efforts to discourage initiation of smoking and to promote cessation have been relatively successful among those of higher socioeconomic status. The way in which these efforts are constructed may be the cause of the differential effects among different socioeconomic groups. For example, policies such as Wisconsin's Clean Indoor Air Act apply only to office settings and not to factories or smaller blue collar worksites. Also, tobacco advertisers have recently directed advertising toward persons of lower socioeconomic status. Examples include targeting Dakota cigarettes for young less educated women, Uptown cigarettes for blacks, and Bucks cigarettes for low income persons.

Comprehensive public health efforts must now be targeted toward persons of lower socioeconomic status in Wisconsin. These efforts should not be limited to education, but should also include worksite prevention and cessation programs, efforts to limit access to cigarettes by minors, and restrictions on advertising. If the recent trends in smoking are not changed, the health and economic burden from tobacco-related diseases, such as, cancer and heart and lung disease, will be greatest among persons of lower socioeconomic status in Wisconsin.

Series coordinators
The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, are coordinating this series for the *Wisconsin Medical Journal.*

Acknowledgment
The authors appreciate the comments of Dan Peterson, MD.

References

1. US Department of Health and Human Services. Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General. USDHHS, PHS, CDC, CCDPHP, OSH. DHSS Publication No. (CDC) 89-8411, 1989.
2. Pierce JP, Fiore MC, Novotny TE, et. al. Trends in cigarette smoking in the United States: educational differences are increasing. *JAMA* 1989;261:56-60.

❑

FYI
Health care workers number 7.5 million – more than 6% of the total private labor force in America.
Source: Bureau of Labor Statistics
A message from The American Medical Association for the Health Access America Proposal

Wisconsin Supreme Court changes certified medical record statute

In a much unheralded action, the Wisconsin Supreme Court amended the evidentiary section of the medical records statutes to allow attorneys to obtain certified copies of medical records of health care providers in certain situations.

Effective Jan 1, 1991, physicians may be required to release certified copies of medical records at a rate of $5 for each request or 10 cents a page and $2 per x-ray copy, whichever is greater, upon a properly authorized request of an attorney involved in a court proceeding in which the records are deemed necessary evidence.

The Supreme Court has the authority to change laws that administer judicial proceedings for the purpose of simplifying and promoting the speedy determination of litigation. This law is intended to allow medical records as necessary evidence in a court proceeding to be produced without requiring the records custodian to appear to authenticate the records. The statute should be used only to promote speedy litigation and not to provide a means to obtain any medical record below cost. This statute does not apply to Workers Compensation records, which are covered under a different statute limiting charges to 25 cents a page or $5, whichever is greater.

The original record certification law applied to hospital records, but is now expanded to include physicians, medical groups, chiropractors, dentists, podiatrists, nurse anesthetists, nursing homes, health care cooperatives, and ambulatory surgery centers. For more information, contact Sally Wencel or Mark Adams of the SMS Office of Legal Services at 1-800-362-9080 or (608) 257-6781.❑

Patients Compensation Fund supports anesthesiology classification change

The WHCLIP/PCF Board of Governors, at its Feb 20, 1991, meeting, supported a SMS representative to the board's motion to reduce the anesthesiologists PCF classification from class 3 to class 2 effective July 1, 1991, based upon improvement in the relative risk ratio. More than $3 million will be saved for the group, with individual savings of $7,712. In addition, the PCF board agreed not to increase fund fees from their current level for a second consecutive year.

Physicians serving on the WHCLIP/PCF board are SMS representatives Richard G. Roberts, MD, of Madison and Walter Moritz, MD, of Fort Atkinson. In addition, SMS member Jack Strong, MD, of Mauston, is a public member of the Board.❑

User fees suggested for National Practitioner Data Bank

The budget submitted to Congress by President Bush offers no federal funds for operation of the National Practitioner Data Bank. Instead, the president's budget suggests that user fees support the program. If adopted, that provision would fall heavily on hospitals, which are required to query the data bank every two years to check on the status of their current medical staff and before granting clinical privileges.

The Bush administration offered a similar suggestion last year, but Congress appropriated funding for the program over the president's objections. Given the tight federal finances, there is no certainty that Congress will take the same step this year.

Currently, hospitals pay $2 per query. As of Jan 25, 1991, the data bank had received more than 285,000 queries on physicians and dentists, and nearly 8,300 reports of adverse actions against physicians or dentists and malpractice payments made on their behalf. In 1989, Congress had appropriated $15.9 million over 5 years for operation of the data bank, with an additional $1.9 million approved for this year. The General Accounting Office estimates that another $9 million may be needed to make necessary improvements in the system to ensure its proper functioning. ❑

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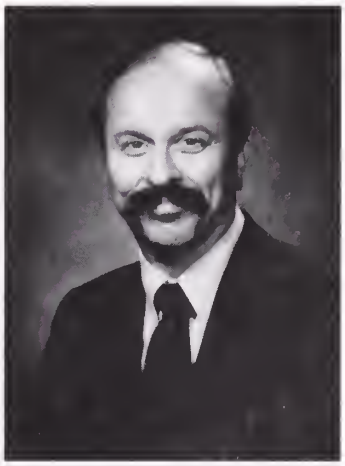

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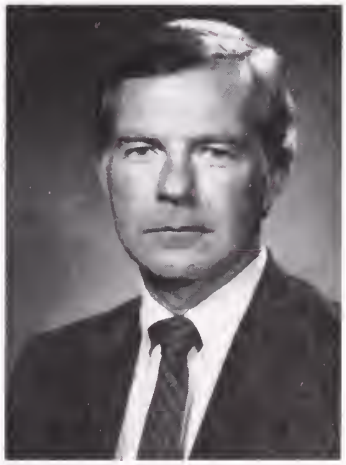

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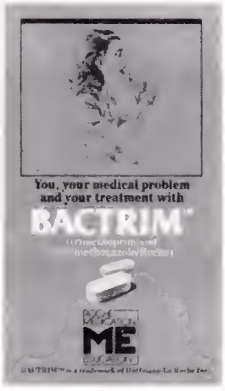

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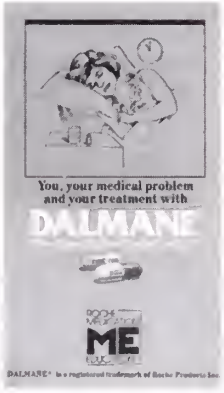

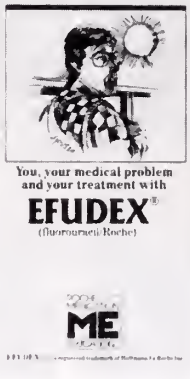

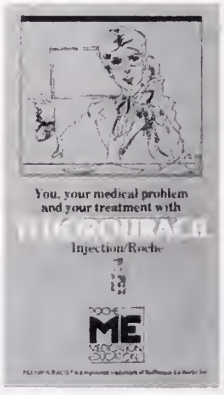

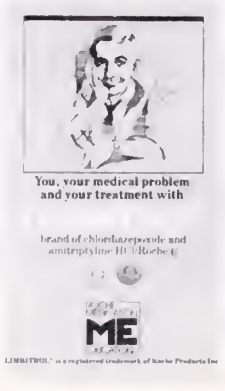

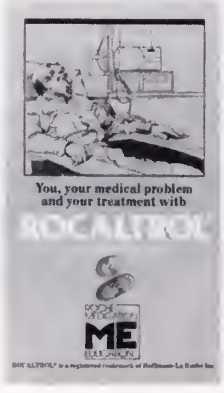

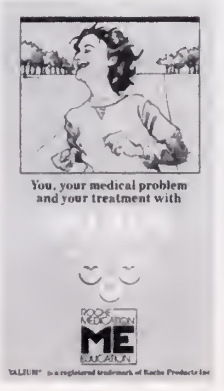

SMS activities: 1990 in review

THE SMS CONTINUES to actively pursue medicine's best interest through a number of important vehicles. Listed below are some of the larger realms of activity and highlights of activities within those areas.

Representing physicians at the capitol
Throughout 1990, the Society's leaders and staff continued to win key victories in the Wisconsin Legislature, including:

- defeating legislation that would have forced physicians to accept Medicare assignment, and, instead, employing the assistance of several state agencies in informing and automatically enrolling certain low-income senior citizens, saving approximately $58 million per year for Wisconsin's physicians;
- assisting in enacting legislation that created a physician loan assistance program, up to $50,000 over 5 years, for primary care physicians who practice in an under-served rural or urban area;
- helping to increase Medicaid reimbursement for obstetric and pediatric services provided by physicians by $4.9 million each year, by July 1990, and by more than $2 million additionally beginning Jan 1, 1991, for a total increase of $7 million per year;
- aiding in enacting legislation creating a power of attorney for health care, allowing patients to designate a health care agent to make health care decisions for them in the event they are unable to act on their own behalf;
- playing a leadership role in AIDS education and prevention by helping to pass legislation that allows health care workers who are exposed to an AIDS patient's blood or body fluids to obtain HIV testing of the patient's blood sample; securing $150,000 in funding for a community-based research consortium undertaking clinical trials of investigational AIDS drugs; and assisting the successful efforts to secure state subsidies for private insurance continuation for AIDS patients who would otherwise lack any insurance or be covered by the state's Medicaid program;
- increasing physician participation in important governmental bodies through the passage of legislation to add a physician to represent clinical labs to the board of the State Laboratory of Hygiene; creating an 11-member Rural Health Development Council; and obtaining physician appointments to legislative study committees;
- obtaining a formal liaison position to the Worker's Compensation Advisory Council to ensure repre-

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sentation of physician's interests in health care issues; and

- securing the support of both the Office of the Commissioner of Insurance and the Department of Industry, Labor and Human Relations in notifying Worker's Compensation carriers that they have no legal right to impose prior authorization or managed care requirements on physicians in Worker's Compensation cases.

Major efforts in the legislature, aided by a statewide grassroots campaign and efforts by the SMS staff, to reform the state's liability system continue in 1990. Many activities that began in 1989 continued. New activities include:

- assisting in the creation of a regional pilot program extending state liability coverage to volunteer physicians; and
- enacting legislation that increased the Patients Compensation Fund investment options, saving physicians millions of dollars.

Spreading the word

The Society continues to inform physicians, the public and state policy makers about the medical profession's views on important health care issues.

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Throughout the year, the Society kept physicians up to date on scientific and socioeconomic developments in the state and nation through its two main publications–the *Wisconsin Medical Journal* and *Medigram*. The *WMJ*, with its new design, continues to publish informative public health columns and the quarterly HMO financial reports from the Office of the Commissioner of Insurance. The important socioeconomic topics covered during 1990 include, among others, the CLIA regulations, the National Practitioner Data Bank, infectious waste regulations, federal anti-patient dumping regulations, Wisconsin's Clean Indoor Air Act, physicians duty to warn, power of attorney for health care, the Cruzan case, Wisconsin's birth and development outcome monitoring program, the Patient Compensation Fund, and the SMS/State Bar Interprofessional Code.

Major changes in the *WMJ* during 1990 were the conversion from typesetting to desktop publishing, the evolution of the Blue Book into two separate documents, and the switch from a membership issue to an up-to-date membership roster available upon request.

The annual medical writing contest for medical students and residents, the annual medical writing contest for graduate nursing students, continue to be a stimulating part of our outreach efforts.

The 26 issues of *Medigram* kept members current on the latest developments in governmental regulations, pending legislation at both the state and federal levels, and activities within the Society. The bi-weekly newsletter also provided technical guidance on the constantly changing requirements of Medicare, Medicaid, WIPRO and other government-related programs.

In addition, the medical student section newsletter, *MSS Notes*, continues to provide information on SMS and AMA member benefits to medical students.

The Communications Division continues to maintain positive working contacts with Wisconsin's health reporters and news editors, arranging interviews, issuing releases and holding news conferences to help spread the Society's message to the public. Important health information is also distributed to the public through the Health Watch brochure series, covering UCR, marijuana use, PartnerCare, melanoma, the liability crisis, and smokeless tobacco. New to 1991, is the legal guide, prepared by the SMS staff.

As a communications effort, the Commission on Public Information, during 1990, expanded its efforts to educate the public on medical issues, enhance the public image of the profession, and assist county medical societies in similar efforts. Part of those efforts included a joint program with the State Bar of Wisconsin to reach out to middle school students to project an anti-drug abuse and alcohol message. In addition, the

commission cooperated with the Wisconsin Alzheimer's Information and Training Center in the development of a physician information packet, produced with SMS as a co-sponsor. The commission has been acting as a liaison between SMS members and the Boy Scouts of America Medical Career Explorer Post program. A number of physicians have indicated interest in this program and plans are underway to continue into 1991. The commission approved underwriting of the public television series, "Seasons of Life," aired on public television, and a weekly radio talk show, "Doc Talk," that airs on WSLU in La Crosse.

Fighting AIDS

Through the Midwest AIDS Training and Education Center, MATEC-Wisconsin, housed at the SMS headquarters, the Society continues to be at the forefront in developing programs to educate and train health professionals in AIDS prevention.

During the past 3 years, MATEC-Wisconsin has provided training and education to more than 7,000 Wisconsin health care professionals. In 1990, the HIV Clinician's Roundtable programs were developed and implemented, targeting primary care physicians statewide. The HIV Management Outline was developed and is now in demand throughout Wisconsin and a number of other states.

MATEC-Wisconsin has also been working cooperatively with the AIDS-HIV Program of the Wisconsin Division of Health to develop the Wisconsin AIDS/HIV Comprehensive Resource Guide, which will be published and distributed this spring to Wisconsin physicians.

The SMS Task Force on AIDS continued to be a leader in directing and influencing the formation of public policy at the state level. The task force has worked closely with legislators on several bills including housing, education, discrimination, financial concerns, insurance continuation, and access to health care.

Keeping you informed

In 1990, the Society–through its meeting planning and continuing medical education staff–planned, promoted and held more than 180 meetings for physicians and their staff, including events such as the Workshop on Health and the SMS annual meeting.

The Commission on Continuing Medical Education supervised the accreditation of 54 hospitals, 23 specialty societies, one county medical society, and one insurance company.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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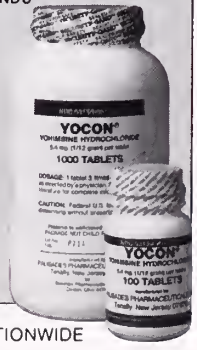

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Explaining the law

In 1990, the Office of Legal Services continued to offer assistance to physicians, medical group managers, and other persons and groups with questions about the law and how it may affect the practice of medicine.

In an effort to address some common legal concerns, the legal staff recently participated in the preparation of a legal guidebook, sent to SMS members this spring. The book is intended as a guide only, and not a legal advice or a substitute for legal counsel. A job of major undertaking, the legal guide is the first publication of its kind for a society the size of the SMS.

The legal staff initiated discussions with state regulators on a number of issues. For example, efforts to prevent certain instances of insurance carrier or employer abuse of the Worker's Compensation system successfully resulted in the Office of the Commissioner of Insurance issuing a bulletin condemning unfair or illegal Worker's Compensation claims practices involving pre-treatment review requirements and claim payments delays.

Supporting physicians in need

More than 450 physicians and their spouses experiencing the trauma of a medical malpractice suit were helped by the Physician Support Program, which was created by the Medical Liability Committee. The program provides physicians named in medical liability cases information concerning medical liability litigation and peer support to help cope with the malpractice suit.

In addition, the Statewide Impaired Physicians Program aids physicians who are impaired through the use of alcohol or other drugs.

Reaching Wisconsin's youth

The SMS Auxiliary sponsored its 28th annual Workshop on Health in Stevens Point. Nearly 900 7th and 8th graders from across the state attended the program. The teens listened to presentations on developing self-esteem, making informed lifestyle decisions and developing responsible behavior. National speakers, Wisconsin physicians and teen peers gave insight on the many difficult choices facing Wisconsin youth today.

Managing medicine

The Society helped more than 4,300 physicians manage their practices more effectively. Nine seminars conducted around the state at 56 different sites, helped physicians better understand the complex changes in technology and government regulations. Topics covered in 1989 included diagnostic coding, procedure coding, Medicare policies and procedures, Medicare coding, Medicare anesthesia, billing and collections, health insurance, Medicaid, and financial planning.

Making sense of Medicare

The SMS staff answered questions and provided free, expert advice to more than 1,400 inquiries from physicians, patients, and the community regarding the ever-changing Medicare and Medicaid regulations. Providing answers over the phone, the SMS staff has been praised for its prompt, accurate and expert advice.

Serving the elderly

During 1990, the Society increased efforts to ensure that Wisconsin's needy senior citizens receive access to health care. PartnerCare, a joint effort of the SMS and the Coalition of Wisconsin Aging Groups, seeks to provide adequate health care to the elderly. In 1990, the Society worked closely with the state to implement a new phase in the PartnerCare program, wherein all senior citizens qualifying for the Homestead Tax Credit Program were automatically sent PartnerCare enrollment cards. As a result of this joint effort, more than 130,000 senior citizens were enrolled in the program. More than 6,000 physicians already participate.

Training for perinatal drug prevention and treatment

The Society was given a $25,000 grant from the state Department of Health and Social Services to fund a physician training program on perinatal drug prevention and treatment. The program will disseminate information to primary care practitioners and specialists in rural and urban areas.

Addressing the issues

The Society's numerous committees, commissions, and task forces have studied and evaluated myriad issues in 1990. More than 75 meetings were held during the year with new policies, based on the recommendations to the Board of Directors, were developed in a number of areas, including in vitro fertilization, surrogate parenting, Medical Assistance reimbursement, tobacco-free environments in physicians' offices and hospitals, community-based research to enhance the availability of investigational drugs, boxing, primary and preventive CPT-coding expansion, and the state mental health mandate.

Providing member benefits

Since its incorporation in 1978, the SMS Holdings Corporation's (previously SMS Services) primary mission has been to develop and implement programs that will benefit SMS members, their dependents and em-

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AND ASSOCIATES

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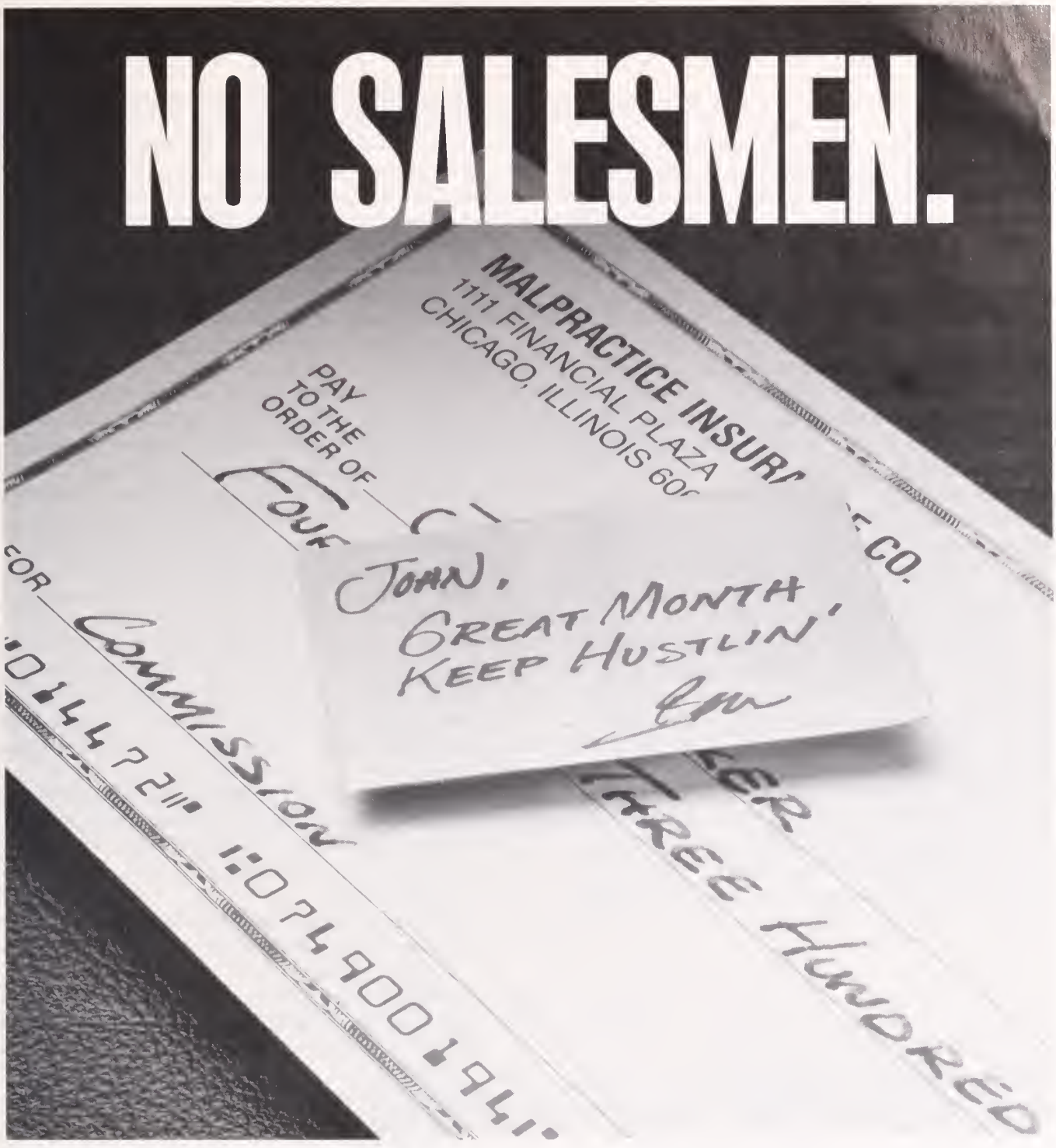

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Continued from page 184
ployees.

During 1990, SMS Services, the insurance division of SMS Holdings, spent considerable time and effort preserving the SMS members' group health and dental plans when the previous carrier, Central Life, would not renew the programs on their annual renewal dates. As a result, more than 1,000 members' coverage were at risk. The health plan was eventually placed with WPS and the dental plan with John Hancock thus maintaining coverage for those members.

A number of new insurance programs were introduced during 1990 including the private pension plan, long-term care and individual disability income. These services provide an excellent product for SMS members at competitive market rates.

In addition, much time and effort have been spent developing Lakeside Administrators, a third party administrator for health and dental partial self-funded plans. Currently, the group is postured to begin marketing its services to small- and medium-sized employers throughout the state.

Lakeside Association Services provides a complete menu of services to other associations which, for a variety of reasons, decide to employ administrative services from outside. Four new groups were added in 1990, two of which are national in scope. Currently, 19 associations with a total membership of 8,500.

A group purchasing program, for medical and nonmedical supplies, was recently added to the many endorsed programs available to SMS members. Administered by R & J Medical Supplies of Milwaukee, the program will help save money for those who participate.

The joke's on you

Henny Youngman used to tell this one: I have a very fine doctor. If you can't afford the operation, he touches up the x-rays. I went up to visit him with my sore foot. He said, "I'll have you walking in an hour." And he did. He stole my car.

Can you top it? Rumor has it that physicians take themselves too seriously, and the WMJ Editorial Board wants to prove the rumor wrong. The Board wants to hear your best doctor jokes--no holds barred. Publication is possible. Send them to: Doctor Jokes, c/o *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❑

Preserving the past, promoting the future

Since 1955, the SMS Charitable, Educational and Scientific Foundation (CESF) has provided financial support to activities that help to enrich the mission of medicine in the State of Wisconsin.

During 1990, the foundation set a new course for the next 2 years, embarking on an endowment campaign in conjunction with the SMS 150th anniversary celebration in 1992. Enhancing the long-range planned giving opportunities and initiating innovative marketing strategies for new fund-raising opportunities were priorities for 1990.

Other events and programs featured during 1990 include the first Charity Golf Classic, held in conjunction with the fall medical issues conference. Leadership gifts from pharmaceutical companies, the business community, clinics, and individuals helped to make this special event a success by raising more than $20,000 with net proceeds of $11,300.

The Milwaukee County Medical Auxiliary's Tiara Ball raised more than $8,000 for the CESF student loan program.

The foundation also contributed to a number of worthy projects through unrestricted contributions raised mainly through the membership voluntary dues statements. Because of the commitment of SMS members, the following projects and programs were granted funding:

- Center of the Study of Bioethics Medical College of Wisconsin, for an educational case-based videotape for physician-patient communication
- Doctors Ought to Care, to sponsor an anti-tobacco poster contest.
- Wisconsin Association of Prenatal Care, to sponsor a project on pre-conceptional preparation and planning for pregnancy
- *Wisconsin Medical Journal* medical student and resident writing contest
- Barbara Scott Maroney Fund, to sponsor a lecture on diabetes.
- Health Management Alumni Association, University of Wisconsin-Madison, for a conference on health care rationing
- Houghton Award scholarships
- Cystic Fibrosis Foundation sponsorships
- Wisconsin Safety Patrols
- Wisconsin Science Congress
- Wisconsin Science Olympiad

More than $104,000 was dispensed in student loans to 46 medical students who are pursuing health care careers, for a total of more than $1.5 million since the program's inception. ❑

Fort Crawford Medical Museum opens May 1

The Fort Crawford Medical Museum is unique among educational and cultural institutions in the Midwest and the nation. Far more than a museum, it stands as a tribute to Wisconsin's physicians who have dedicated their lives to ensuring the health of the state's citizens. The museum is also a singular tool for educating the public about the prevention and treatment of injury and disease, the nature of medical care, the value of the physician-patient relationship, and the importance of keeping one's health.

The Fort Crawford military hospital, which has been designated a national landmark, and the related museum are located in Prairie du Chien near the Mississippi River. On this site in the 1830s, Dr William Beaumont carried out his famous experiments on the physiology of digestion.

The actual planning for the museum began in the 1930s when the SMS placed a granite memorial near the crumbling remains of the second Fort Crawford, which had been abandoned in 1872. In the mid-1940s, the SMS House of Delegates endorsed furnishing the hospital building as a museum. The property was deeded to the SMS Charitable, Educational and Scientific Foundation in the 1950s, and the SMS approved the completion of the museum complex, known officially as the Museum of Medical Progress. In 1964, the Stovall Hall of Health was added, which provided additional exhibit space.

In 1980, the Fort Crawford Medical Museum Endowment Fund was established to provide financial support for the museum. Over the years, more than 200,000 visitors have toured the museum, yet it continues to face financial hardship and is in need of frequent repair.

The first 500 persons who contribute $1,000 or more to the Fort Crawford Medical Museum Endowment Fund will join a select group known as the Beaumont 500 and will receive a specially designed Beaumont medallion. The number of Beaumont 500 members reached 59 in 1990.

During 1990, active promotion of the museum resulted in a growth in attendance and greater visibility for the site. The 1990 Civil War Encampment Weekend held in July also proved to be a success and attracted museum visitors from throughout the Midwest.

The Museum Gift Shop, as well as the county medical society auxiliaries are helping to promote and sell limited edition prints and notecards of the mural "Dr Beaumont's Waiting Room," which graces one wall of the Fort Crawford room at SMS headquarters in Madison.

For more information about the Fort Crawford Medical Museum, please contact Julie Hein at the CES Foundation at 1-800-545-0634 or 608-257-6781. Ext. 323.❑

SMS helps obtain release of OMB funds

Aggressive SMS and AMA lobbying for funding of Medicare claims processing has resulted in the Office of Management and Budget (OMB) agreeing to release approximately $75 million of the Medicare contractor $101.3 million contingency fund. While the OMB did not release the full amount requested, the Health Care Financing Administration (HCFA) has indicated that $75 million would be sufficient to avoid predicted lengthy delays in physician payments had the funding not been released.

Previously, WPS-Medicare had notified physicians that they could experience a slow-down of claims processing due to a shortage of Medicare carriers operational funds and that this lack of funding could result in a 60-day delay in claims processing by the end of September. Although the monies have been released, minor claims processing delays of 4 to 5 days may still occur.

The OMB reconsidered the release of funds after encountering a barrage of protest from the SMS, the AMA, various other health care and senior citizen groups, including the Wisconsin Medical Group Management Association and more than 70 members of Congress. A number of Wisconsin congressmen had contacted the OMB office and were instrumental in helping to release the funds. They include Jerry Kleczka (D-Milwaukee), Dave Obey (D-Wausau), Toby Roth (R-Appleton), Jim Moody (D-Milwaukee) and Scott Klug (R-Madison).

For more information, contact Trish Ramsay of the SMS staff at 1-800-362-9080 or (608) 257-6781.❑

Physician briefs

The * indicates an SMS member.

Sridar V. Vasudevan, MD,* of Mequon, was recently elected president of the American Academy of Pain Management. Dr Vasudevan, who practices physical medicine and rehabilitation, is the medical director of the Pain Rehabilitation Center at Elmbrook Memorial Hospital in Brookfield. He is also the president of the Wisconsin Society of Physical Medicine and Rehabilitation.

Mark Kroll, DO, of Milwaukee, will be joining the Luxemburg Clinic in July. A graduate of the University of Osteopathic Medicine and Health Sciences in Des Moines, Dr Kroll is serving a residency in family practice at St Luke's Medical Center in Milwaukee.

Daniel Thearle, MD,* and **John Konsek, MD,*** of Neenah, were recently added to the board of the Theda Clark Regional Medical Center. Dr Thearle, a general surgeon, and Dr Konsek, an oncologist, were appointed by officials at the Novus Health Group.

Paul LeMarbre, MD,* of Waukesha, has joined the medical staff at Waukesha Memorial Hospital. Dr LeMarbre graduated from the University of Minnesota and has completed fellowships in oncology and hematology.

David B. Tange, MD,* of Mosinee, was recently awarded membership in the American College of Physician Executives, an educational and professional organization for physicians in medical management. Dr Tange serves as chief executive officer and is a practicing physician at Central Wisconsin Primary Care.

Vladmir Kovacevic, MD,* an anesthesiologist, of Milwaukee; **Mark Meier, MD,*** a family practitioner, of Milwaukee; **Thomas Kowalski, MD,*** a pediatrician, of Greendale; **S. John Kim, MD,** a psychiatrist, of Milwaukee; **David Czarnecki, MD,** a radiologist, of Milwaukee; **Russell Dabrowski, MD,*** a cardiologist, of Milwaukee; **John Whitcomb, MD,*** emergency medicine, of Elm Grove; **Irwin Margolis, MD,*** an internist, of Milwaukee; and **Carmela Barr, MD,*** an obstetrician/gynecologist, of Milwaukee, were elected as departmental chiefs at St Luke's Medical Center in Milwaukee.

Philips T. Bland, MD,* of Westby, will be honored in LaCrosse for a lifetime of service to medicine and his community. Dr Bland will receive the Ralph Hawley Distinguished Service Award, given yearly to a University of Wisconsin Medical School alumnus who has contributed to the medical profession and to the well-being of the local community.

Arnold Slyper, MD, of Glendale, has been appointed assistant professor of pediatrics at the Medical College of Wisconsin. Dr Slyper is a graduate of University College Hospital Medical School in Cambridge, United Kingdom.❑

SMS clarifies definition of medical malpractice payment relative to the National Practitioner Data Bank

Since the National Practitioner Data Bank (NPDB) became operational last year, concern has been expressed over what constitutes a "medical malpractice payment" for purposes of reporting to the NPDB. For clarification, each person or entity, including a medical malpractice insurer, that makes a payment under an insurance policy, self-insurance, or otherwise for the benefit of a physician, in settlement of or in satisfaction in whole or in part of a claim or judgement against such physician must report that information to the NPDB.

For purposes of reporting to the NPDB, medical malpractice payments are limited to exchanges of money. Such payment must have resulted from a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on an allegation of a physician's negligence or failure to provide health care services.

A waiver of debt is not considered a payment and should not be reported to the NPDB. Only payments made for the benefit of a named physician, pursuant to a written claim, are reportable. For more information, contact Sally Wencel of the SMS Office of Legal Services or Kay Hutchison of the SMS Division of Medical Policy and Practice at 1-800-362-9080 or (608) 257-6781.❑

County society news

Marathon. Stephen P. Goff, MD; Jay Kaufman, MD; Donald C. Gibson; and Jonathan L. Bayba, MD, have been accepted to membership in the society.

Oneida-Vilas. Mark L. Adams, SMS legal council, was the guest speaker at the February meeting of the Oneida-Vilas County Medical Society. Michael J. Kretz; Gary A. Bailey, MD; Steven R. Coenen, MD, have been accepted to membership in the society.

Outagamie. Twenty-four members were present at the February meeting of the society. Richard Zimmen, guest speaker, spoke on "Is there a drug problem in the valley?" Officers for 1990-1991 are Peter V. Podlusky, MD, president; Jan C. Bax, MD, vice president; and Donald C. McKee, MD, secretary. Henry Chessin, MD; David R. Finch, MD; Peter V. Podlusky, MD; and Charles F. Dungar, MD, were elected to serve as delegates to the SMS annual meeting in Milwaukee. Karen A. Beimborn, MD, of Little Chute; Robert R. Cornwell, MD, of Appleton; and Gregory A. Johnson, MD, of Kaukauna, have been accepted to membership in the society.

Sheboygan. David Ross Smith, MD, has been accepted to membership in the society.

Walworth. Mehboob Quareshi, MD, has been accepted to membership in the society. ❑

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SMS allowed to participate in physician demonstration project

THE SMS HAS LEARNED that Wisconsin will be included in a Health Care Financing Administration (HCFA) demonstration project that will study seven national Medicare screens from carriers in 13 states. The SMS had requested to be part of the project which is designed to test the effect of publishing Medicare medical review screens. The project, began March 1, 1991, and running through March 31, 1992, involves computer screens that Medicare's insurance carriers use for prepayment review. The project was ordered by Congress and is an outgrowth of an anti-hassle campaign conducted by the AMA.

"I commend HCFA's support of the demonstration project and am very pleased that Wisconsin has been chosen to participate in the project," said SMS Secretary-General Manager Thomas L. Adams, CAE. "The State Medical Society believes that the project will demonstrate that physicians use the information appropriately and perhaps improved quality and controlled costs may be achieved through this project."

Since the mid-1980s, HCFA has required its 34 insurance carriers to use a set of national screens that flag certain claims for a more in-depth review of medical necessity. Carriers, however, have claimed that knowing the certain "triggers" enabled physicians to avoid review. Physicians, on the other hand, have often undergone lengthy appeals where payment was often denied for necessary as well as unnecessary procedures.

The AMA took its concerns to HCFA which proposed the demonstration project to see how releasing the screens would influence physician behavior. The project will study seven national screens: routine foot care, comprehensive office visits, chiropractic, intermediate hospital visits, skilled nursing facility visits, consultations, and comprehensive visits in all settings. The number and choice of screens to be released will differ from carrier to carrier and will range from one to four. The exact "trigger" points associated with the screens will also vary among states. WPS-Medicare will release screening parameters for Comprehensive Office Visits (one every 180 days) and for Intermediate Hospital Visits (seven visits per 30 days).

Following the release of the screens, data on all claims for the involved services will be collected for one year and compared with claims for the same services in the previous year. Changes in utilization and payment levels will then be analyzed as researchers look for an increase in the total or average payments per physician or beneficiary. Watch Medigram for more information. ❑

Highlights of the 1990 SMS membership survey

To provide the SMS ad hoc strategic planning committee with guidance from the Society's members, the SMS surveyed its members and more than 500 medical residents. The surveyed garnered a 20% return rate from the membership and a 7% return rate from the residents. Below are some of the more notable findings.

The survey respondents indicate that they want their professional associations to be more proactive on issues facing medicine. For instance, 31% said they wanted the SMS to be at the forefront of change, 49% wanted it to be progressive in making changes, and 15% wanted it to change with the times. Less than 1% said the SMS should maintain the status quo.

When asked to rate the SMS's relative effectiveness in a number of activities, the respondents provided the following ranking, from most effective activity to least: communication with the profession, representation to the government, member benefit programs (insurance, etc), political candidate support (WISPAC), analysis of emerging social and economic programs, scientific and education activities, consulting services to the members, patient advocacy, and communication with the public.

When asked to rank the importance of several activities in which the Society is engaged, 96% of the respondents indicated that "representing medicine's views to the state legislature" was either very important or somewhat important. Communicating with the public, representation to regulatory agencies and to Congress, and developing new policies on issues facing medicine were all ranked as very or somewhat important by more than 90% of the respondents.

The survey respondents also indicated a number of areas in which they would like to see the SMS become more involved, the top two responses being education of the public about health care and improving the public's image of physicians.

The survey was conducted by the Charlton Research Company, and an executive summary of the results is included in the 1991 House of Delegates packet. The full survey results will be published in an upcoming *WMJ*. A summary of the recommended amendments to the 1988 SMS Strategic Plan, which grew, in part, from these results, is also in the packet. The SMS Board of Directors is recommending approval of the amendments by the House.❑

SMS to physicians: question RBRVS software packages

The SMS is aware that several consulting firms are selling computer software packages which simulate the impact of the RBRVS on physicians' offices. Physicians have questioned the value of purchasing such packages in preparation for the implementation of the new payment formula in January 1992.

The SMS cautions physicians that they should review such packages carefully prior to purchase. The preliminary RBRVS figures released by the Health Care Financing Administration (HCFA) in September are expected to be modified as HCFA continues to refine the fee schedule.

Any software package based on the preliminary data can only provide initial estimates, and should include the refined figures as they are developed. The next publication of the RBRVS values was scheduled for April 1, 1991, and modifications will be made to the scale until final adoption this fall.

The SMS will sponsor half-day seminars in June explaining the RBRVS system and the fee schedule published April 1. If you have any questions about the new Medicare fee schedule, please contact Trish Ramsay of the SMS at 1-800-362-9080 or (608) 257-6781.❑

Questions?

Call the

State Medical Society

toll-free at

1-800-362-9080

Medical records alert: beware of unauthorized release without consent

Medical offices should be careful when handling requests for confidential patient information by entities other than insurers, third party payors and medical review organizations. The SMS recently learned that nonmedical review organizations under contract with employer groups are attempting to obtain confidential information from medical offices that may not otherwise be authorized under Wisconsin's medical record access laws.

The SMS Office of Legal Services cautions that the medical records law does not permit access to medical information that is not needed for billing, collection or payment of claims by payors or others affiliated with payors without consent. Without a contract and proper informed written consent, physicians are not required to provide confidential medical information to any private data collection organization as a condition of prompt payment.

For information, contact Sally Wencel or Mark Adams at 1-800-362-9080 or (608) 257-6781.❑

Obituaries

David J. Werner, MD, 82, of Milwaukee, died Dec 2, 1990, in Milwaukee. Dr Werner was born Aug 16, 1908, in New London, and graduated from Marquette University School of Medicine. His internship and residency were completed at Milwaukee County General Hospital. Dr Werner served in the United States Navy from 1942 to 1946. He was a member of the Milwaukee Gynecological Society, Wisconsin Society of Obstetrics/Gynecology, the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Loyola; and two daughters, Nancy Meyberg and Jacquelin Scarbrough.

Vance LaMar Baker, MD, 84, of Wauwatosa, died Jan 3, 1991, in Wauwatosa. Dr Baker was born Jan 29, 1906, in Springfield, Ohio, and graduated from Marquette University School of Medicine. His internship was served at St Joseph's Hospital, Milwaukee, and his residency completed at the Chicago Maternity Center. Dr Baker served in the Pacific, Asiatic and American theatres during World War II. He practiced medicine in the Milwaukee area for more than 50 years. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are two sons, Howard and John Baker, and four grandchildren.

Kenneth F. Manz, MD, 79, of Neillsville, died Jan 15, 1991, in Neillsville. Dr Manz graduated from the University of Wisconsin Medical School-Madison, and served his internship and residency at Augustana Hospital in Chicago. He practiced medicine in Burlington and Black River Falls for 8 years before moving to Neillsville in 1946. He began his practice with the late Dr M. V. Overman, and together they formed the Neillsville Clinic. He was a member of the Clark County Medical Society, the SMS, and the AMA. Surviving are his widow, Elinor; two sons, Peter J., of Neillsville, and Paul C., of Neward, Calif; two daughters, Mary Bruno, of Chicago, and Katherine Cowett, of Providence, RI.

Robert E. McMahon, MD, 77, of La Crosse, died Jan 18, 1991, in La Crosse. Dr McMahon was born Dec 30, 1913, in Jersey City, NJ, and gradu-

Continued on page 192

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑

Continued from page 191
ated from the College of Physicians and Surgeons, Columbia University, in New York City. His internship was served at St Vincent's Hospital in New York, prior to entering the US Army in 1941. His residency was completed at University Hospital, Cleveland. In 1952, he became a member of the La Crosse Clinic and during his tenure was chief-of-staff at St Francis Hospital. In 1964, he became the first full-time physician and director of the University of Wisconsin-La Crosse Health Service. Dr McMahon also was the co-founder of the cardiac rehabilitation program at the university. He joined the medical staff at the Gundersen Clinic Ltd, in 1970, and retired in 1984. Dr McMahon was president of the Wisconsin College Health Association and director of Western Wisconsin Health Planning Organization. He also was a member of the Governor's Health Planning Task Force and the Alcohol and Drug Abuse Committee. He was a member of the La Crosse County Medical Society, the SMS, and the AMA. Surviving are his widow, Barbara; five daughters, Patricia, of Chicago; Betsy Pourier, of Warwick, RI; Kate Lowe, of Casselberry, Fla; Barbara Jordan, of La Crosse; and Molly McMahon, MD, of Rochester, Minn; one son, Robert, of Onalaska; and 11 grandchildren.

Stephan I. Wojcechowskyj, MD, 67, former Milwaukee physician, died Jan 27, 1991, in Brandenton, Fla. Dr Wojcechowskyj was born Sept 20, 1923, in Russia, and graduated from Ruprecht-Carl University Medical School, in Heidelberg, Germany, in 1952. His internship and residency was completed at Mt Sinai Hospital, Hartford, Conn, and Memorial Hospital in Danville, Va. Dr Wojcechowskyj also served a residency at Milwaukee County Hospital. Surviving are his widow, Lillian; two sons, Stephan Jr, and Leo, of Sarasota, Fla; and a daughter, Julia A. Swanson, of Honolulu.

Marshall O. Boudry, MD, 86, of Waupaca, died Feb 1, 1991, in Waupaca. Dr Boudry was born July 28, 1904, in Fond du Lac, graduated from the University of Minnesota Medical School, served his internship in the US Navy and completed his residency at the Mayo Clinic, in Rochester, Minn. He had practiced in Waupaca until his retirement. He was a member of the Waupaca County Medical Society, the SMS, and the AMA. Surviving are two sons, John, of Antigo, and Robert, of Neenah; two daughters, Mary Jackson, of Jackson, Miss, and Helen Dedman, of Neenah. ❑

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

January 1991

Bass, Marjorie D., Washington Island
*Beran, Frank V., Fort Atkinson
*Fisher, David R., Madison
*Holzgrafe, Robert E., Waukesha
Jefferson, James W., Madison
*Jerzak, James T., Green Bay
*Kagen, Allan E., Milwaukee
*Keller, Thomas A., Manitowoc
*Kennedy, Timothy J., Green Bay
*Krohn-Gill, Kathryn A., Merrill
*Levin, Randall M., Milwaukee
*Maassen, Stephen J., Oshkosh
*Martens, William E., Wauwatosa
*Meyers, F. Bradford, Jefferson
*Mohammad-Zadeh, Ali A., Green Bay
*Nielsen, William A., West Bend
*Peterson, Stanley E., Fort Atkinson
*Starling, James R., Madison
*Sundglass, Jaswinderjit S., Green Bay
*Van Dommelen, Bruce A., Sheboygan ❑

Wisconsin Medical Journal

Instructions for authors

Authorship

Manuscripts are considered with the understanding that they have not been published previously and are not under consideration by another publication.

Each manuscript must be accompanied by a cover letter containing the following sentence: "In consideration of the *Wisconsin Medical Journal*'s taking action in reviewing and editing this submission, the author(s) hereby transfer(s), assign(s), or otherwise convey(s) all copyright ownership to the *WMJ* in the event that this work is published in the *WMJ*." All co-authors must sign the letter.

The cover letter must also designate one author as correspondent and provide a complete address and telephone number. All coauthors should have contributed to the study and manuscript preparation. They should be thoroughly familiar with the substance of the final manuscript and be able to defend its conclusions.

The *Journal* expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. All funding sources supporting the work should be routinely acknowledged on the title pages, as should all institutional or corporate affiliations of the authors.

Editing

All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style. Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

Manuscript preparation

• Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.

• Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.

• Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.

• Organization for scientific papers:

Abstract—150 words or less, stating the problem considered, methods, results and conclusions.

Methods—Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results—Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion—Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

References—Limit to 20. Authors are responsible for the accuracy and

completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

• Acknowledge all illustrations and tables taken from other publications, and submit written permission to reprint from the original publishers.

Style

• Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors*.

• Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")

• Authors are responsible for supplying the full and correct names of drugs. Use generic names of drugs, unless the specific trade name of a drug is directly relevant to the discussion. If the author so desires, brand names may be inserted in parentheses.

• Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.

Review process

Each scientific manuscript is reviewed by the medical editor and the members of the editorial board. The opinions of outside consultants may be sought at the medical editor's discretion. The medical editor has the final decision as to whether a scientific paper will be published.

Publication support

Authors of articles that are longer than 2 typeset pages (including tables or illustrations), or roughly 5 typewritten pages, may be asked by the editorial board to provide publication support in the amount of $100 per typeset page beyond the second. Such support is not mandatory and is not asked for until after a paper is accepted for publication. Provision of support helps defray the cost of publishing the *Journal* and is left to the conscience of each author.

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Dermatologist, psychiatrist, allergist, internal medicine, family practice. A progressive, 126-bed two-hospital system is seeking the above specialties to establish practices in the Iron Mountain area of Michigan's Upper Peninsula. Must be BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully staffed, special diagnostic department. Contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; ph 906-779-4500. 4-5/91

Iowa practice opportunity in Estherville. Family physician needed to join established rural clinic. Located close to outdoor recreational areas, offers easy access to larger metropolitan cities in Iowa and Minnesota. Competitive salary and signing bonus available. Opportunity of practice ownership. Contact Bill Tendle, LifeSpan, 800 East 28th St, Minneapolis, MN 55407; ph 1-800-248-4921. 4-6/91

Community of 2,000, 50 miles NE of Minneapolis/St Paul, seeks additional family practitioner. Located on the St Croix River and Minnesota border. Practice consists of 13 family practitioners, 2 internists, 2 general surgeons and 1 orthopaedic surgeon. Many specialists available on a part-time basis. Attached to a 90-bed hospital with comprehensive services available. Very stable medical group with pleasant working conditions in a continuous growth mode. Guaranteed first year salary with second year partnership. Fringes include excellent retirement package and car. Contact Lenny Libis, administrator at 715-483-3221. 4-9/91

West Bend, Wisconsin. Seeking full-time and part-time emergency physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided, benefit package, and incentive bonus plan available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p4/91

Northern Lakes. Family practice opportunities in northeast Minnesota, northwest Wisconsin and Upper Michigan. Offering spectacular natural beauty, abundant recreational activities and competitive packages. Contact Susan Sowieja, Northern Lakes Health Care Consortium, 1017 East First St, Duluth, MN 55805; ph 218/726-5587. p4/91

Lake Winnebago, Wisconsin area. Seeking director, full-time and part-time emergency physicians for low volume 60-bed hospital. Attractive compensation, full malpractice insurance coverage and benefit package available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49484; ph 1-800-253-1795 in Michigan 1-800-632-3496. p4/91

Internal medicine physician board-certified/board eligible to join 25 physician multi-specialty group in Winona, Minnesota, with existing ten physician internal medicine department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact: J.B. Knuesel, Administrator, Winona, Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 4-6/91

Antigo, Wisconsin. Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p4/91

Emergency department physician, Wisconsin (Stoughton). Emergency department staff physician Stoughton Hospital expanding to two full-time ED positions supplemented by contract service. 7,000 visits/year ED located in community of 9,000, fifteen miles southeast of Madison metropolitan area. Other responsibilities include departmental administrative activities and employee health. Prefer physicians that are Board-prepared or board-certified in emergency medicine or family practice. Competitive compensation package including full benefits as hospital employee and malpractice insurance. Contact Steven J. Novacheck, MD, Medical Director of Emergency Services, 900 Ridge St, Stoughton, WI 53589; ph 608-873-2264. 4/91

Kewaunee, Wisconsin. Seeking part-time emergency physicians for low volume facility located 1/2 hour east of Green Bay. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 South Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p4/91

BC/BE internist/family practice physician to join group of three established in NE Wisconsin. Weekday schedule; flexible hours; excellent salary and benefits. Artwich Clinic, Oconto Falls, WI 54154. p4-6/91

Medford, Wisconsin. Seeking director, full-time, and part-time emergency physicians for moderate volume facility located in northern Wisconsin. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc, 2240 South Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p4/91

Family practice. Gorgeous Wisconsin community where patients really care about you. Group, top financials, great call coverage. "Signing Bonus." Call your midwest FP connection: Bill Sherriff, J. Sherriff & Associates, 10955 Granada, Overland Park, KS 66211; ph 1-800-533-0525. p4/91

Family practice, Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multi-specialty groups of thirty-five. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest, family-oriented location offering exceptional four season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in those communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449 or call 1-800-826-2345, extention 5376. 4-7/91

RATES: 55 cents per word, with a minimum charge of $25 per ad.

BOXED AD RATES: $30 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg*, copy for the August issue is due July 1.

SEND TO: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Physicians Exchange

Continued

Illinois (Chicago, West & Central areas). Seeking emergency medicine physicians for full-time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. Benefit package available to full-time physicians. For more information contact: Emergency Consultants, Inc, 2240 South Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p4/91

General internal medicine, Marshfield Clinic, 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

General surgeon to join a progressive 12-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 4tfn/91

Help! We need volunteer camp health care staff! Camp Phillip, Wautoma, Wis, is seeking qualified WELS or ELS physicians, registered nurses, or practical nurses to staff our medical office this summer. Volunteer a week, and your child goes free to camp. Medical staff needed for the following weeks: 6/30-7/6; 7/7-7/13;7/21-7/27; and 8/4-8/10. For more information contact: Mr Cliff Schmoldt, Program Director, Rte 3, Box 203, Wautoma, WI 54982; ph 414-787-3680. 4-5/91

Emergency medicine, Marshfield Clinic-Lakeland Center, located in the beautiful Lakeland area of northern Wisconsin, is seeking an ER physician. This individual must be BE/BC in FP, IM, or EM. This opportunity offers a challenging variety of patients, within a multi-specialty group representing thirteen specialties available for back-up. The Lakeland area offers a unique recreation oriented lifestyle and this position with a 48 hour work week will afford you the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you want to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

Experienced BC psychiatrist with interest in the psychological problems of the medically ill. Want to develop adjunctive treatment protocols that integrate both mind/body and psychology of healing models in specific short and long-term caseloads. Programs would be in support of basic medical treatment and include survival strategies for chronic and life-threatening illness. Would like to establish contact with anyone in or near the Milwaukee area having a similar interest or specific need. Contact: Psychiatrist, 1545 West spruce Ct, Milwaukee, WI 53217-1128; ph 414-351-4034. 4-6/91

Family practice. Three-physician group seeks fourth MD(BC/BE) to join growing practice located within one hour of Madison and Milwaukee. Full benefits, first-year salary guarantee. One hundred and two bed community hospital located within one block from office. Send resume to Richard C. Holden, MD, PO Box 49, Watertown, WI 53094; ph 414-261-5204. 4-6/91

Dean Medical Center, a 220+ physician multi-specialty group is actively seeking a BE/BC general internist with interest in pediatrics to work at the Stoughton and Evansville, Wisconsin, offices located approximately 20 miles from Madison. Call would be shared with two internists based in Stoughton. There is also four family practice physicians and one general surgeon located at the Stoughton office, along with full subspecialty support in Madison. Excellent compensation and benefits provided with this position. Please submit CV and letter of introduction to Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715, or call work 608-252-8022 or home 608-276-8989. 4-5/91

ASSOCIATE DIRECTOR. The Appleton Family Practice Residency seeks a board-certified residency-trained family physician to join a well-established 18-resident program with an innovative competency-based curriculum. Affiliated with the University of Wisconsin Medical School, we are a community-based program intent on mutual growth of residents and faculty. Responsibilities include teaching, patient care, administration, and research. Appleton is a rapidly growing community with excellent schools in the heart of economically stable northeast Wisconsin–a great place to live and raise a family. Send CV or contact John Allhiser, MD, Program Director, Appleton Family Health Center, 229 South Morrison St, Appleton, WI 54911; ph 414-832-2789. 3-4/91

Family practitioner. An exciting opportunity for a BC/BE family practitioner to join one of Wisconsin's largest multi-specialty groups. Over 160 physicians represent over 30 specialties. Offering a guaranteed salary with incentives and full benefit package. All clinics have on-site lab and x-ray, and are serviced out of one centralized hospital. Excellent schools and recreational opportunities share small town living with all the amenities of a large community close by. Just 20 minutes away you'll enjoy Big Ten collegiate sports, four beautiful lakes, and many family and community oriented activities. Obstetrics is required. For further information call collect: Laurie Glowac, Physicians Plus Medical Group, 345 W. Washington Ave, Madison, WI 53703; ph 608-282-8017. 4/91

Mantiwoc, Wisconsin. The Manitowoc Clinic, an 18-physician multi-specialty group is seeking BC/BE general internists and obstetricians/gynecologists. Excellent practice, financial and quality of life opportunity. Send CV or contact James Robinson, Administrator, 601 Reed Avenue, Box 1270, Manitowoc, WI 54221-1270. Telephone (414) 682-8841. 4-6/91

MANITOWOC CLINIC
601 Reed Avenue, Manitowoc, WI 54220

Physicians Exchange

Continued

Internist, family practice physicians BC/BE. Exceptional opportunity to join our established busy clinic located in Milwaukee. Practice includes subspecialty physicians, in-house laboratory, x-ray, business department, etc. A unique opportunity! Please send CV or call: Jonathan Slomowitz, MD, Mitchell Medical Center, 1672 S 9th St, Milwaukee, WI 53204; ph 414-383-4700. 4/91

Internal medicine - Green Bay, Wisconsin. Thirty-one Dr multi-specialty group, ten Dr IM department. Guaranteed first year salary with incentives plus excellent benefits. Excellent patient base in well respected practice. University community with diverse economic base and excellent schools. Superb quality of life and water and land recreational opportunities. Contact John M. Blackburn, Administrator, West Side Clinic, sc, PO Box 19070, Green Bay WI 54307; ph 414-496-4700. 4-6/91

Family physician. Located only 45 minutes from Minneapolis/St Paul, the residents of Baldwin are proud of their community for good reason. It boasts progressive businesses, a healthy retail district, accredited educational programs, and unlimited recreational activities! One additional family physician is needed to join this well-established practice; currently, a physician's assistant and four family physicians provide care for this community. Contact: Loriese A. Stoll, Ramsey Clinic, 640 Jackson St, St Paul, MN 55101; ph collect 612-221-3067. 3-4/91;6/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; ph 906-563-9243 or office 906-563-9255. 3-4/91

Minnesota communities seek family physicians. Private practice opportunities in attractive settings offer guarantees plus incentives, benefits, and hospital support. Locate your practice in Minneapolis, Richfield, Hopkins, Eden Prairie, Wayzata, Mound, Montgomery, Monticello, Lakefield, Litchfield, Springfield, or St James. Contact: Jerry Hess, Abbott Northwestern Hospitals, 800 East 28th St, Minneapolis, MN 55407; ph 1-800-248-4921. 3-5/91

Family practice opportunity as partner, and eventually to assume a well-established practice with flexibility and potential, and opportunity for surgery and OB if desired. Cooperative backup coverage available. Resort community with a number of industries, centrally located between Chicago, Milwaukee, and Madison. Modern 90-bed hospital. Contact: Glenn A. Smiley, MD, Delavan, WI 53115; ph 414-728-3441. 3-5/91

Opportunity for BC/BE family physician to join well-established physician in Christ-centered family practice. Newer offices located adjacent to hospital. A 1991 FP resident graduate would be welcome. Please contact Thomas R. Jensen, MD, 8800 West Lincoln Ave, West Allis, WI 53227; ph 414-321-7373. 3-4/91

Non-invasive cardiologist. Four-physician, single-specialty cardiology group has an immediate opening for a BE/BC non-invasive cardiologist. Echo, doppler, holter, and treadmill are established in-clinic. Full invasive and surgical programs are established. The practice serves a large and expanding regional referral area in mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, PC, Attn: N. Polzin, 4701 Towne Center Rd, Suite 201, Saginaw, MI 48604. 3-5/91

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UW Office of Rural Health
5721 Odana Road
Madison, WI 53719

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7-12/90;1-6/91

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Contact Dr. John Hansen, Medical Director, Group Health Cooperative, One South Park Street, Madison, WI 53715, 608-251-4156. GHC is an equal opportunity/affirmative action employer. 1tfn/91

Rice Clinic Medical Center

The Rice Clinic, an expanding 29 physician multispecialty group, is seeking BC/BE general internist to join Internal Medicine department consisting of five general internists, two nephrologists and one gastroenterologist. Very desirable university city with many outdoor recreational and cultural amenities. Attractive income and ownership arrangements. Other areas of expansion may provide opportunity for spouse if also a physician. Send CV to: Paul R. Ford, Administrator, Rice Clinic, SC, 2501 Main Street, Stevens Point, WI 54481 or call collect: 715-344-4120. 3-4/91

Physicians Exchange

Continued

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Emergency physician, Milwaukee. Excellent opportunity for BC/BP emergency or otherwise qualified physician to join a stable, well-established, board-certified fee-for-service group staffing a 560-bed tertiary care teaching hospital's ED. 35,000 visits annually. Excellent specialty back-up. Peak double coverage on a daily basis. Salary starts at $130,000 per year for 40-hour work week, plus paid malpractice coverage and four weeks paid vacation/CME in first year. Exceptional benefits including paid vacation that grows to 12 weeks per year. Equitable partnership available. Send CV to I. Gailans, MD, FACEP, 5000 W. Chambers St, Milwaukee, WI 53210; ph 414-447-2171. p3-4/91

Family practice opportunity, Black Hills of South Dakota. An exceptional opportunity awaits for the right individual to join a progressive multi-specialty group practice located in the heart of the Black Hills of South Dakota. In addition to a very competitive compensation/benefit package, we offer a terrific call coverage schedule. Due to substantial economic development in our area, we are looking for this additional family practice physician. Contact: Darrel Riddle, Administrator, Black Hills Medical Center, 71 Charles St, Deadwood, SD 57732. 3-4/91

Beautiful southern Wisconsin. Riverview Clinic, a 60-member multi-specialty clinic in Janesville, is seeking a third general surgeon. Clinic is adjacent to a modern, well-equipped hospital and has three primary care satellites in neighboring communities. Janesville, a city of 53,000, is centrally located between Madison and Milwaukee and close to Chicago. Excellent benefit package and salary guarantee first year with a full partnership thereafter. Send CV to Ronald Karzel, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 2-5/91

Family practice physician wanted to join solo practitioner in a very progressive suburb of Green Bay, Wisconsin. Clinic is equipped with lab and x-ray facilities. Located near large recreational area. Send CV or contact M. J. Falk, MD, 2353 Ridge Rd, Green Bay, WI 54304; ph 414-494-9685. p11-12/90;1-4/91

Orthopaedic surgeon, Black Hills of South Dakota. Outstanding opportunity to assume an established orthopaedic practice with a progressive multi-specialty group in the beautiful Black Hills of South Dakota. Modern clinic facility adjacent to an accredited, acute-care hospital and in the heart of a community experiencing substantital economic development. Attractive compensation/benefit package including paid professional liability insurance. Direct inquiries to D. Riddle, Administrator, Black Hills Medical Center, PC, 71 Charles St, Deadwood, SD 57732; ph 605-578-2364. 3-4/91

Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 2-6/91

Emergency medical opportunity, Eau Claire, Wisconsin. Excellent opportunity to join a three-person private contract group. Twelve hour shifts. 17,000 annual visits. Competitive hourly rate with full comprehensive benefits. For further information please contact: Krista P. Greiner, Health Care Consultant, 2075 W. Big Beaver, Ste. 600, Troy, MI 48084; ph 313-649-2010. 2-4/91

Urgent Care. Seeking BC/BE MD for 36 MD multi-specialty group on Lake Michigan in southeastern Wisconsin. Prefer specialty training in FP, IM, EM, surgery. Partnership possible within 18 months. State-of-the-art facility and equipment. Competitive compensation package negotiated. Beautiful setting. Abundance of recreational cultural activities. Contact: Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. p2-4/91

Urologist. Beautiful southern Wisconsin. BC/BE urologist to join 60-member multi-specialty clinic adjacent to 250-bed hospital. Community of 55,000 with excellent lifestyle. Good benefits and salary guarantee with full partnership after one year. Send CV to: Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St., Janesville, WI 53545. p2-7/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary $30,000 plus paid health, life, malpractice, 401K (total package worth in excess of $40,000). Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

Family practice or internal medicine. Riverview Clinic, a 60-member multi-specialty facility has a position available at our regional clinic in Delavan. No night call or hospitalization responsibility. Excellent lifestyle and benefits in beautiful southern Wisconsin. Send CV to Stan Gruhn, MD, Riverview Clinic, 580 N Washington St, Janesville, WI 53545. p12/90;1-5/91

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full-time staff physician. Approximately 10,000 annual visits. Compensation to be negotiated. Pleasant area in which to live, near Devil's Lake and the Baraboo Hills. Also, Madison nearby. Contact: Thomas Warwick, Executive vice President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; 608-356-5561, ext 492. 11tfn/89

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

MD needed. Full or part-time position available at women's health center providing abortions in metropolitan Milwaukee area. Salary and hours are negotiable. Contact Chris Gorski at 414-442-2400. 12/90;1-5/91

Internal medicine and infectious disease. Multi-specialty group seeking BC/BE general internist and infectious disease specialist to join 19-member department (5 general internists and 14 subspecialists including one infectious disease specialist). Clinic is physically attached to a 206-bed hospital. Two state universities and private liberal arts college enhance the cultural life of the community (population is approximately 100,000) and, with Minnesota's lakes country just a half-hour drive away, outdoor activities abound. Competitive salary, excellent fringe benefits package and malpractice paid. Contact: Dr John Hicks, Director, Recruiting Division, 1702 South University Drive, Fargo, ND 58103; ph 701-280-3338 or 701-280-8520. 11-12/90;1-4/91

For Sale

For sale medical clinic building adjacent to Clintonville Hospital in central Wisconsin. Designed to accommodate five doctors, including exam rooms, surgery areas, pharmacy area, business office, and much more. Contact O'Connor Sales 715-823-5144. 4/91

Announcement

Newly Developed Wisconsin Lipid Club. We would like to invite your participation in the newly developed Wisconsin Lipid Club. Our goal is to bring together physicians with a common interest in lipid disorder management. This club, with meetings planned every two to three months in strategic locations throughout Wisconsin, will provide a forum for us to meet, discuss interesting and problem lipid cases, and share ideas and information. We will also bring in well-known experts to speak to us about practical issues relevant to lipid disorder management. We hope this club will promote interest and expertise among Wisconsin physicians, and improve our ability to evaluate and manage lipid disorders. For more information and dates of upcoming meetings contact: WI Lipid Club, Gordon Schectman, MD, Division of Endocrinology, Metabolism and Clinical Nutrition, 9200 W Wisconsin Ave, Milwaukee, WI 53226; ph 414-259-3010. 4/91

Medical Meetings-Continuing Medical Education

July 31 - August 4, 1991: Annual Convention of IDAA at Hyatt Regency Hotel, Vancouver, British Columbia. Info: IDAA 1991, All Destinations Travel, 1290 Homer St, Vancouver, BC, Canada V6B 2Y5; ph 604-683-6966. g4-6/91

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

State Medical Society
of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1991-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1991 - April 18-20: Milwaukee
Wyndham Hotel
1992 - April 23-25: Milwaukee
1993 - April 15-17: La Crosse
Convention Center, Radisson
1994 - April 14-16: Milwaukee

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday; the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

Nov 4-8, 1991; 57th Annual Scientific Assembly of the American College of Chest Physicians, San Francisco Marriott and the Moscone Center in San Francisco. Info ACCP, Division of Education, 3300 Dundee Rd, Norethbrook, IL 60062-2348; ph 708-498-1400. g4-8/91

Nov 7-10, 1991: 10th Annual Scientific Meeting of the American Pain Society at the New Orleans Hilton, New Orleans, La. Info: APS, 5700 Old Orchard Rd, 1st Fl, Skokie, IL 60077; ph 708-966-5595. g4-8/91

AMA

June 23-27, 1991: Annual AMA House of Delegates, Chicago.
December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.

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Yocon®
PBBS Equipment Corp 150
Physicians Insurance Company
of Wisconsin ..... IBC
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Health Access America

The AMA proposal to improve access to affordable, quality health care.

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We hear that a lot from our patients these days. For the 33 million people who have no health insurance, it's a particularly acute problem.

That's why the AMA has launched a proposal to improve access to affordable, quality health care. It's called *Health Access America*. The message is being sent to Congress, the media, labor and management organizations, concerned groups like AARP, and your fellow physicians.

Simply, *Health Access America* proposes health insurance coverage for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America's physicians are leading the way to reforming the health care system by speaking out on these critical issues.

To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association

on behalf of member physicians and their patients.

A message from The American Medical Association for the Health Access America Proposal

We've never settled claims without your consent.

That's the most important thing you need to know about us.

From the day we started doing business, we offered you this feature. That's because we have always listened to the physicians who own us. When a claim is filed against a physician, we have always known it's much more than just dollars on the line. A professional reputation is at stake.

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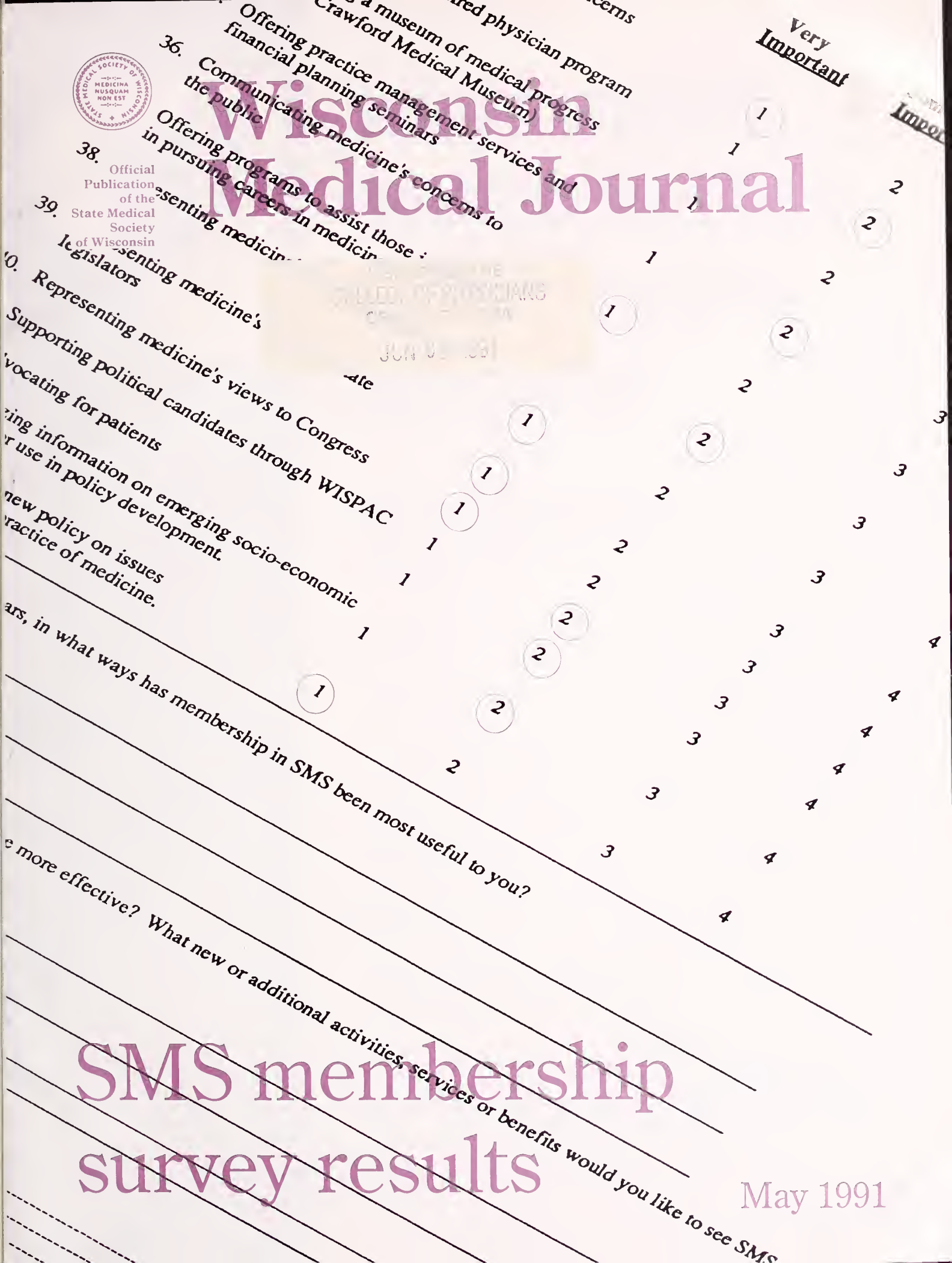
Wisconsin Medical Journal

Official Publication of the State Medical Society of Wisconsin

SMS membership survey results

May 1991



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May 1991 Vol. 90 No. 5

Opinions

203 *Secretary's report*
Getting involved, staying involved
by Thomas L. Adams, CAE, Madison

Editorials

204 Farewell to two friends of the *WMJ*
by Richard D. Sautter, MD, Marshfield

206 An anchor for the future
by John P. Mullooly, MD, Milwaukee

Letters

206 SMS politics risks alienation of SMS members
by Duane M. Koons, MD, Viroqua

208 Financing catastrophic health care costs
by D.L. Mullen, DDS, Beloit

208 Priorities
by Owen Miller, MD, Waukesha

210 C-section editorial draws fire
by David L. Hoogerland, MD, Milwaukee

210 C-section editorial earns praise
by George Nemec, MD, Woodruff

212 The author responds
by Russell Lewis, MD, Madison

Scientific

215 Malaria in Wisconsin 1981-1989: A review of cases and update on chemoprophylaxis
by Stephen W. Hargarten, MD, and W. Paul McKinney, MD, Milwaukee and Dallas

219 Human ehrlichiosis diagnosed in Wisconsin
by Ian Gilson, MD, and Paula Jones, MD, Milwaukee

223 Electromagnetic induced shock wave therapy of ureteral calculi
by J. Vincent Thomalla, MD; Ian L. Goldman, MD; Michael Y. Roy, MD; Michael C. Seelen, MD; and David A. Eisberner, RN, Marshfield

227 Kawasaki syndrome in Wisconsin
by Anna Marie B. Windsor, MD; Wendy L. Schell, MS; and Jeffrey P. Davis, MD, Madison

231 Instructions to authors

Socioeconomic

235 *Public health*
Data-based cancer control programs: a public health response
by Judith A. Zvara, MA; Dennis E. Anderson; Patrick L. Remington, MD; and Henry Anderson, MD, Madison

237 SMS helps develop cost containment proposals

Organizational

239 A new hand assumes the SMS helm

240 SMS membership survey executive summary
by Charles F. Rund and Carolyn R. Palmer, Charlton Research Company

250 Physician briefs

250 County society news

252 News highlights

252 Obituaries

Wisconsin Medical Journal

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Secretary's report
Getting involved, staying involved

THIS SPRING, all SMS members received the new SMS publication, *A Physician's Guide to Wisconsin Health Law*. Although this book is free, it is one of the most valuable references of its type anywhere and, I believe, will prove to be one of the more valuable benefits of joining the Society. Let me emphasize the word *benefit*: Unlike some other state associations, the SMS does not charge its members for this book.

(There is a $25 SMS member fee for each additional copy after the first free one, and a $25 fee to office staff affiliated with SMS member physicians. Physicians who are not members of the SMS and their staffs must pay a fee of $95.)

The *Guide* helps take the mystery out of a broad range of laws and regulations affecting your medical practice. It also provides you with Wisconsin-specific information that is vital to avoiding legal pitfalls and fulfilling your legal obligations. There is no substitute for qualified legal counsel, but this book can save you time and money when you need information rather than advice or representation.

The *Guide* can also help you be a more effective physician citizen and a more influential leader in your community. Information is power, and particularly so in politics. This book will serve as an authoritative reference when you are communicating with your elected leaders in Madison and Washington, DC, and when you are urging your peers and neighbors to add their voices to yours.

The 142-page book is large enough to be useful and small enough to be handy. It contains sections on regulations, medical management, professional liability, AIDS and HIV, and Worker's Compensation. You'll find the key word subject index in the back a real time saver.

Thomas L. Adams, CAE

The *Guide* will be updated every 2 years, coinciding with the start of each new session of the Wisconsin's Legislature, so do not be shy about telling us what you think of the book. Are there frequently asked questions or commonly encountered issues that we have not addressed? Let us know.

The best opportunity for letting us know whether the Society is proceeding on the right course at the right pace is the House of Delegates sessions at the annual meeting, but that opportunity was neglected by a

Continued on next page

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great many delegates this year. Too many. Of the 226 delegates to the House, only 141 participated. Of our 55 county medical societies, 18 went unrepresented in the deliberations of the 1991 House of Delegates. Of our 29 specialty sections, 9 had no representation.

Participation is the key to survival in any democratic structure. In America, participation is patriotism in action; in the Medical Society, participation is responsibility fulfilled. Responsibility to yourself, to your peers, to your patients, to your county society or specialty section constituents, and to your profession's past, present and future. For the delegates and alternates to the House, that responsibility is particularly heavy because they have been selected by their peers as leaders. The weight of leadership is the obligation of involvement. An uninvolved leader is not leading.

My concern over those SMS districts, counties and specialties that went unrepresented at the 1991 House of Delegates is more than a philosophical concern for the principles of democracy. Such abstractions are essential and merit our careful consideration, but there is something more. We are not living in an era of nuance and refinement; we are in the middle of an age of hammer and anvil. This is a time when the iron frame of the American health care system will be fired and struck until it assumes a new shape, a shape better suited to today's health care needs. Only those who are willing to reach into the coals, to wield the hammer, to strain the sinews and dirty the hands will lay claim to the right to forge the new American medicine.

Fortunately, the iron remains hot. There is still time to strike.❑

Editorials
Farewell to two friends of the *WMJ*

THIS YEAR the *Wisconsin Medical Journal* is regretfully losing two of its Board members. Dr George Kindschi has served on the Editorial Board for nine years and has offered much assistance to myself and the previous editor. His guidance and support will be missed.

Dr Fredric Hildebrand, another valuable member of the Editorial Board has resigned due to other commitments. His counsel also will be missed. The Board has accepted his resignation with regrets.

The strength of the *Wisconsin Medical Journal* rests with the quality of the people who serve on the Editorial Board. I hope that their replacements will be as dedicated, resourceful, and incisive as these gentlemen have been.

–Richard D. Sautter, MD
medical editor ❑

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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An anchor for the future

"An anchor for the future" is both a history of the Medical College of Wisconsin and a history of the Southeastern Regional Medical Center. This volume, recently authored by Norman Engbring and published by the Medical College of Wisconsin, is a well-told story and should be of interest to all medical graduates of Marquette University School of Medicine and its successor the Medical College of Wisconsin. It also will be of interest to all who are involved in health care administration and the dynamics of community involvement.

In the forward, written by former *Milwaukee Sentinel* reporter, Robert W. Wills, the story of the medical center is spelled out. How John Doyne, the Milwaukee County executive and Edmund Fitzgerald, the retired Northwestern Mutual Insurance Company executive, combined political and community resources to bring about the realization of the medical center is recounted. The difficulties of Marquette University School of Medicine are recorded.

It becomes crystal clear as the years go on that the fate of the projected medical center and the survival of the medical school are inextricably intertwined. How our leaders, both medical and community, addressed and solved these problems is told. In looking back over these years and reviewing what has been accomplished by these leaders, one must rejoice at the successes with which these leaders have brought about.

Engbring divides his history into seven parts, concentrating his theme around the seven deans of the medical school. These are: Louis F. Jermain, 1913-1926; Bernard F. Mc Grath, 1928-1933; Eben J. Carey, 1933-1947; John S. Hirschboeck, 1947-1965; Gerald A. Kerrigan, 1965-1977; Edward J. Lennon, 1978-1985; and Richard A. Cooper, 1985 to present.

While the early days of the school (1913 - 1947) are interesting and revealing, the most interesting section of the book includes the deanships of Hirschboeck and Kerrigan. It is during these years (1947-1977) that one comes to grips with the survival of the school and the creation of the medical center.

The painful separation of the medical school from the university, the wrenching name change of the school, the addition of state aid, and the growth of the full-time faculty are recalled. For those of us who have lived through these times, this book will be a pleasure to read. Engbring's style and his mastery of details in weaving this pleasing tapestry in such a delightful way is bound to please the reader and will stand as a solid contribution to the history of medicine in the state of Wisconsin.

–John P. Mullooly, MD
Milwaukee ❑

Letters
SMS politics risks alienation of SMS members

To the editor: I still remember my first day of medical school when a State Medical Society representative exhorted us to join the Society to help "protect our interests." Being unsure whether my interests agreed with his, I declined the offer. Over the next 8 years, I continued to ignore the AMA's frequent invitations, choosing instead to join the American Academy of Family Physicians. It seemed much more willing to recognize systematic problems in American medicine and consider structural changes to deal with them.

After moving to rural Wisconsin, I decided to join the state and county medical societies, partly to feel more represented and partly to facilitate interaction with my new colleagues. I have come to enjoy the *Wisconsin Medical Journal* as it introduces me to various statewide experts and focuses on medical issues in Wisconsin.

Then I received the February 1991 issue featuring US Rep Scott Klug on the front cover. The feature article revived my deep misgivings regarding organized medicine and raised these questions in my mind.

Why was this particular politician singled out for publicity on the cover of our journal? Is he an election trophy demonstrating the political power of the medical society? If so, the reward will likely be limited given the

Continued on page 208

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Continued from page 206
typically short tenure of conservative representatives in traditionally liberal districts like the 2nd district, which includes Madison.

Is it because he articulated clear policy objectives regarding the future of American medicine? In the article, he acknowledges the problems of the uninsured, but prefers to give the problem back to state government to solve. He clearly states that Medicare should be cut, which most certainly would affect physicians.

Perhaps the Medical Society is simply proud that he defeated the long-term incumbent Bob Kastenmeier, whom Klug describes as a "very vocal proponent of socialized medicine." It is indeed ironic that the AMA currently supports the RBRVS fee schedule and proposes the expansion of Medicare and Medicaid in its Health Access America proposal. Wouldn't these have been stigmatized as socialized medicine a few years ago by the same organization?

My point here is that the State Medical Society of Wisconsin risks alienating many current and prospective members through these high profile political gestures. Organized medicine has had difficulty in the past two decades recruiting new members because of the divergence in values voiced by its leadership compared to those held by large segments of the physician population. If we are unable to develop an inclusive political philosophy that fosters the participation of a broad majority of physicians, we will certainly become a minority voice in the complex discussions of change which lie ahead.

–Duane M. Koons, MD
Viroqua ❑

Financing catastrophic health care costs

TO THE EDITOR: The economic monster, Catastrophic Health Care Cost, has arrived. And our only defense may be a special restricted tax called a value-added tax. Only the very wealthy can afford prolonged, intensive medical treatment. Much of the rest of catastrophic health care cost is picked up by Medicaid. But many people fall through holes in the system. Often people of modest means must sell or give everything away to qualify for government aid. We must find a way to provide every citizen with access to the benefits of dialysis, chemotherapy, and complicated surgery.

To solve the problem, we must first define it. Catastrophic health care costs may be defined as all costs above an affordable ceiling or limit. All services below the ceiling can be managed in a traditional one-to-one relationship between the patient and doctor.

Today, catastrophic illness can bring cancellation of a company policy, sky-rocketing premiums, or destruction of a family unit. A national policy is necessary to deal with calamities of this size. And funding must come from an adequate source such as the highly effective value-added tax, but it must be restricted by law for use only in a national health insurance pool.

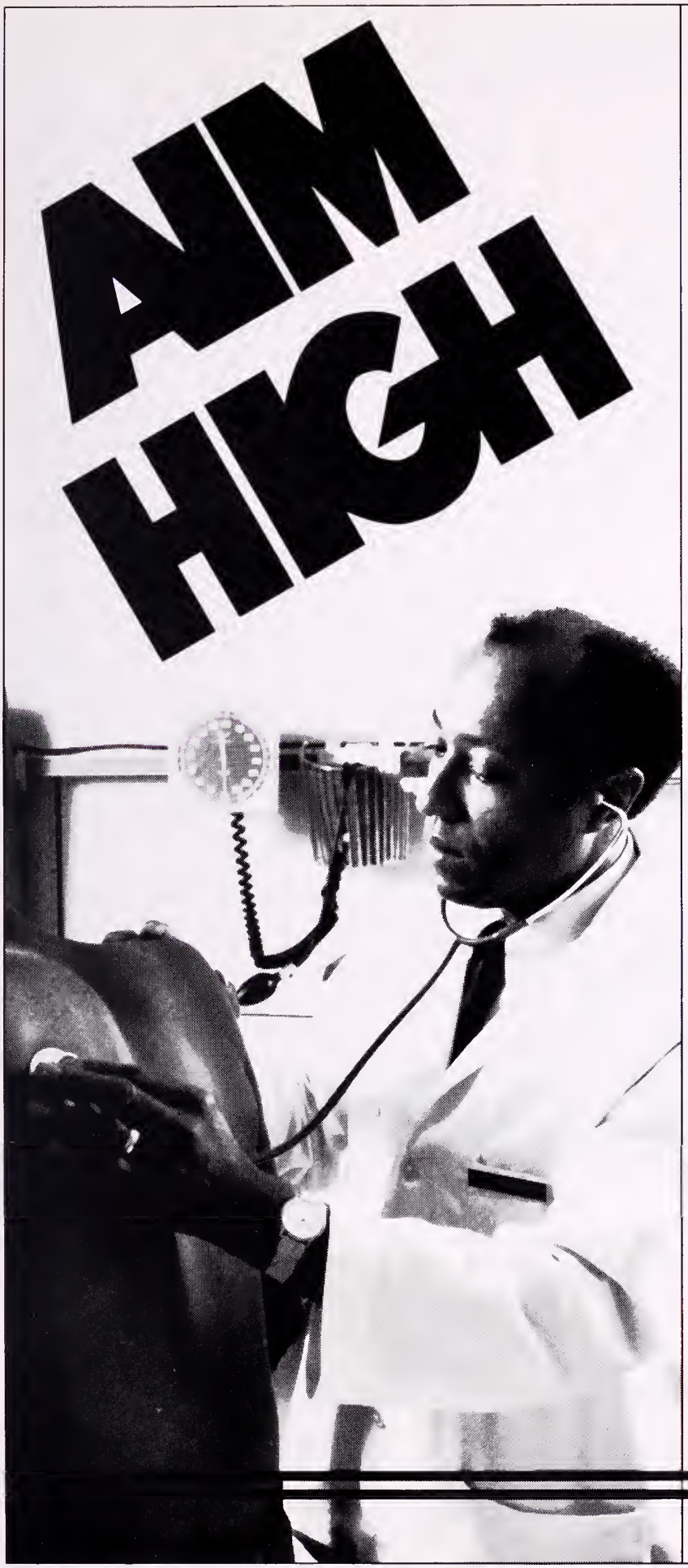
Implications of a comprehensive catastrophic health care system are far reaching. For example, the homeless who are mentally ill could receive appropriate long-term care and shelter. And the elderly can look forward to affordable long-term nursing care. The scope of this health care program will be enormous. Catastrophic health care costs will have grown into a dragon. Like St George, we need to find a weapon to slay the

Continued on page 210

Priorities

TO THE EDITOR: On the same day that the United States government announced that there would be a reduction in Medicare Part B benefits it made two other general news announcements. Physicians and also Medicare beneficiaries should consider these news announcements. They were the United States would grant Turkey $85,000,000 for weapons, and would forgive Egypt $6,000,000 it had borrowed to pay for weapons.

–Owen Miller, MD
Waukesha ❑



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Continued from page 208
dragon. A consumption tax like the value added tax is that weapon.

Collecting a value-added tax can be achieved by using mechanisms similar to those used by most of the other nations in the world. Existing Medicaid bureaucratic machinery could be used with very little modification to administer the funds.

Several unsavory aspects of this basically beneficial concept will have to be resolved. First, there's the question of how to initiate the insurance pool. Should the affluent be ineligible? Or if they receive benefits, should their estates be made to replenish the insurance pool?

And finally, after much soul searching and debate, the matter of triage must be resolved. Besides discouraging useless procedures, government agencies can influence costs by setting reasonable limits on reimbursements. Triage is absolutely necessary, and must be listed specifically in legislation to prevent abuse by care providers, family, and bureaucrats.

Everyone loves to hate this idea, but it spreads risk evenly. The final legislation may be very different from the first conception. But the basic idea is elegant in its simplicity, and could eventually become a very useful and functional law.

–D.L. Mullen, DDS
Beloit ❑

C-section editorial draws fire

TO THE EDITOR: Dr Russell Lewis' recent editorial "The question of cesarean sections," was very disturbing. While I fully understand Dr Lewis' well intentioned advice, it is difficult for me to believe that the *Wisconsin Medical Journal* would actually publish this sort of an opinion.

Our national cesarean section rate continues to be a disgrace, although recent efforts have shown that it has hopefully peaked and is starting to, in fact, decline. We have successfully lowered the cesarean section rate in our own hospital from a high of 18% in 1982 to 9.4% in the last academic year. This reduction has taken place with no apparent concomitant increase in fetal or maternal morbidity, and, in fact, the opposite appears to have occurred. It is interesting to note that Dr Kierin O'Driscoll of Dublin, who has written extensively on the subject, would still probably consider our (St Mary's Hospital) cesarean rate twice that which it should be.

Dr Lewis' three criteria for doing a cesarean defy any obstetric logic, and, in fact, smack of elitism. The notice that someone "prominent in the community" should have a cesarean for a borderline indication, while the person in the next room who is perhaps not so "prominent" should deliver vaginally suggests not only poor obstetrics but abandonment. I would be interested to know the author's criteria for "prominence" and would appreciate his suggestions as to how we might apply this to our own clinic population.

Dr Lewis further argues that several lawsuits have been lost because of failure to do a cesarean section. It is interesting to note that this tide also is beginning to turn, in that a physician in Milwaukee was recently successfully sued for doing an unnecessary cesarean section.

While I don't necessarily disagree with his final comments regarding the need for improved reimbursement for physicians who dutifully observe a protracted labor course and suc-

Continued on page 212

C-section editorial earns praise

TO THE EDITOR: I read with great interest Dr Russell Lewis' editorial on C-sections and I highly applaud his attitude and the conclusions that he has drawn.

Having practiced obstetrics in family practice for close to 30 years, I share the conclusions that he drew and I applaud his courage in expressing his views in the *Wisconsin Medical Journal.*

–George Nemec, MD
Woodruff ❑

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Continued from page 210
cessfully completed a vaginal delivery over that of a repeat cesarean section. I personally do not believe that cost containment is the crux of the issue. The heart of the matter is, in fact, improved patient care and decreased infant and maternal morbidity and mortality. As our European colleagues have well demonstrated, this can be done with no increase in cesarean rate.

While I fully understand Dr Lewis' sentiment and frustration toward a legal system which often times seems poised to attack even the best of care, I think his comments are misguided and a throwback to the type of reasoning that put us where we are in regard to cesareans. Hopefully, with increased efforts on all of our parts, our C-section rates and, ultimately, our perinatal mortality rates can approach those of the other "first world" nations.

–David L. Hoogerland, MD
Milwaukee

Editor's note: As a service to its readers, the *Wisconsin Medical Journal* maintains as open an opinion forum as possible. Please see the "Opinion policy" box, published monthly in the opinion pages, for guidelines.❑

The author responds

I APPRECIATE Dr Hoogerland's response to what I had hoped would be a provocative stance on cesarean section.

My first and perhaps most important premise was that, with the advanced technology of the 1990s, a good hospital cesarean section is as safe for the baby and mother as is a vaginal delivery. Dr Hoogerland did not really attack that premise, which to me means that the method of birth becomes a matter of free choice. I still feel that in these enlightened days the mother-to-be should, if she wishes, make the decision and not have the doctor impose his or her preference. Given this, a section rate of 50% could be justified.

If both procedures equally safe, and if–as Dr Hoogerland believes–"cost containment" is not the crux of the issue, what, other than cost, is behind the drive to lower section rates? To me, cost is it.

My strongest plea was to do sections at the *first* sign of fetal distress. This opinion was based on three cases reported to me by friends. All three physicians, despite detecing abnormalities while monitoring the fetus, tried to be conservative and closely watch their patient in labor. All three physicians finally performed sections when problems resurfaced, and all instances resulted in mentally handicapped infants and subsequent lawsuits. The physicians lost these suits because juries tend to believe so-called experts who tell them the section should have been performed earlier. They use the child's handicap as "proof." It may be that this trend has changed. I would hope so, but as an obstetrician I would not be ready to risk it as yet.

I was impressed to read that "a physician in Milwaukee was recently sued for doing an unnecessary cesarean section." To me, that is a most frightening situation. The door is now open to the lawyers to sue regardless of a physician's well-considered decision. Certainly, a medically uninformed jury should not have the responsibility for this decision.

For all of my career in obstetrics, our section rate in Marshfield was 5% or less. We put many mothers through long hours of hell, but it was believed to be safer. I believe that Dr Hoogerland's section rate of 9.4% is about right and can see no need to lower it to conform with our "European colleagues." It has always interested me that half of the obstetricians want to emulate statistics from countries like Sweden and the other half defend our figures, pointing out that differences are plausible with population differences.

Finally, Dr Hoogerland challenges some of my criteria for doing sections, perhaps justifiably. These criteria were originally promulgated by Dr J.B. Vedder, who practiced in the 1920 and '30s in a small town in central Wisconsin. He strongly believed, as I do, that in the eyes of the public a physician who does a C-section with poor results is believed to have done everything possible. On the other hand, if the physician does not do the section and has a poor result, he or she will be blamed for not doing the section. Obviously, one of his thoughts about a "prominent" person had to do with establishing and maintaining a good reputation in that small community. I may be a naive country doctor, but I truly believe the same standard does exist in Milwaukee (but cannot and should not be discussed here).

Dr Hoogerland concluded his letter by hoping that "our C-section rates

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and, ultimately, our perinatal mortality rates, can approach those of other 'first world' nations." I agree about the perinatal mortality rates, but do not believe that lower section rates will provide that answer.

Incidentally, I thank Dr Hoogerland for not disagreeing with my comment that physicians should be reimbursed more for supervising and doing vaginal deliveries.

-Russell Lewis, MD
Madison ❑

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Malaria in Wisconsin 1981-1989: A review of cases and update on chemoprophylaxis

Stephen W. Hargarten, MD, and W. Paul McKinney, MD
Milwaukee and Dallas

Malaria continues to be a significant cause of travel related morbidity and mortality for US citizens. Yet there have been no previous analyses of malaria cases reported in Wisconsin. To provide timely information to Wisconsin physicians, the authors present a review of reported malaria cases in Wisconsin for the years 1981 through 1989, and an update of current Center for Disease Control malaria chemoprophylaxis. *Wis Med J* 1991;90(5):215-217.

MALARIA CONTINUES to be a major source of travel related morbidity and mortality to US citizens and other nationalities.[1-3] Each year, 8 to 10 US citizens die from malaria, and approximately 1,000 cases are reported to the Centers for Disease Control (CDC).[1] To provide current information for Wisconsin physicians, a review of reported cases of malaria in Wisconsin for the years 1981 through 1989 are presented.

Methods

Malaria is a Type II reportable infectious disease, with notification required within 72 hours to Wisconsin Department of Health and Social Services. Cases are submitted by physicians from Wisconsin using Form 4151. Age, sex and race of the cases were abstracted, along with the county of origin of the patient and the type of malaria. Reports on travel destination and other pertinent material were abstracted when present.

Analysis of Wisconsin cases

During the years from 1981 through 1989, there were 75 cases of malaria reported in Wisconsin, an average of eight cases per year. There were no deaths during the study period. The age range was from 9 years of age to 72 years of age. There were 52 males and 22 females with one case unknown. Almost half of the cases involved white patients (Table 1). Six-

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Table 1.–Malaria cases in Wisconsin, by race, 1981-1989.

Race	No.	%
white	35	47
Asian	18	24
black	8	11
other	9	12
unspec.	5	6
total	75	100

Table 2.–Malaria organisms reported in Wisconsin, 1981-1989

Organism	No.	%
P Vivax	31	41
P Falciparum	25	33
P Malariae	2	3
P Ovale	1	1
unspecified	16	22
total	75	100

Table 3.–Malaria cases in Wisconsin, 1981-1989, by country of origin.

Country	No.
African continent	
Nigeria	5
Togo	1
Ivory Coast	1
Kenya	1
Ghana	1
Tanzania	1
unspecified	9
Total:	19
Indian subcontinent	
India	5
Nepal	1
Pakistan	2
Afghanistan	1
Total:	9
Central and South America	
Mexico	2
Ecuador	1
Columbia	1
Nicaragua	1
"Amazon"	1
Total:	6
Far East	
Southeast Asia	6
China	1
Papua New Guinea	2
Total:	43

teen of the 18 Asian cases were reported between 1981 and 1985.

Twenty-seven (27%) of Wisconsin counties reported malaria cases. Dane County accounted for 20 cases (27%), and Milwaukee County for 19 (25%). The counties next most frequently reporting malaria were Brown and Fond du Lac, each reporting three cases. Twenty-three additional counties reported one or two cases during the study years.

The malaria organism most often reported was Plasmodium Vivax (Table 2).

In 43 (56%) of the cases reported, the continent or country of origin of the malarial case was known. "Africa" or African countries were most commonly reported (Table 3).

Discussion

Malaria has been reported every year in Wisconsin throughout the 1980s, particularly in the highly populated areas of Dane and Milwaukee Counties.

It remains important for physicians to obtain a travel history when examining a patient who, despite having previously good health, has an unexplained fever.

The racial distribution of patients with malaria has changed in Wisconsin, with whites and blacks accounting for the majority of cases in 1986-1989, and Southeast Asian cases occurring primarily in the first half of the 1980s. Nationally, the majority of malaria cases are in patients who reside in the United States but travel to other countries to visit relatives (Hans Loebel, personal comments, CDC, 1990).

Attempts to define the risk of malaria for travelers have been difficult. Available information suggests West Africa is the region with the highest risk to travelers.[4] We were unable to obtain information to define the risk of contracting malaria for Wisconsin patients. We do not know how many patients travel to countries with malaria. Also, we do not know how many travelers received pretravel advice or chemoprophylaxis. It is concerning that 41% of the malaria cases in Wisconsin are P Vivax–an organism susceptible to chloroquine alone. This suggests that a number of these patients have not received pretravel advice for chemoprophylaxis. When advising patients, physicians need to be aware of the changes in the distribution of chloroquine resistant strains of malaria.[5,10]

Current recommendations from CDC for the prevention of malaria among travelers can be found by obtaining volume 39 #RR-3 of the MMWR.[6]

Table 4 summarizes the advantages and disadvantages of the current chemoprophylaxis medications.

Patients should be counseled on appropriate personal protective measures for mosquito bites, such as insect repellent, screened accommodations, bed nets, trousers and long-sleeved clothing whenever travel is planned to countries where there is a high incidence of malaria.

A new medication which increases the level of protection from malaria for Americans traveling to certain tropical countries is now available for general use. Mefloquine (Lariam), was licensed for marketing by the US Food and Drug Administration in May 1989, but was not in distribution in this country until mid-February 1990.

Mefloquine is now considered the preventive medication of choice for persons traveling to areas of the world where strains of malaria are resistant to chloroquine or Fansidar. Adults traveling to the Dominican Republic, Haiti, Central America west of the Panama Canal, the Middle East, and Egypt may still use a weekly dose of 500 mg of chloroquine phosphate for malaria prevention. Persons traveling to any other areas of Central and South America, sub-Saharan Africa, the Indian subcontinent, Southeast Asia, and Oceania where malaria transmission occurs should use mefloquine unless certain other medical conditions make its use more hazardous.

Mefloquine is not recommended for children who weigh less than 30 lbs and pregnant women (pregnancy should be avoided for 2 months after the last dose of mefloquine), or persons using medications for heart conditions that interfere with the electrical conduction pathways. Persons who must perform tasks requiring highly refined coordination and spatial discrimination, such as pilots, or persons with a medical history of seizures or psychiatric disorders should be advised not to take Mefloquine. Minor side effects such as stomach upset and dizziness usually

last only a brief period. Rarely, persons using mefloquine may develop hallucinations or convulsions, but these are usually associated with higher doses of this drug used for treatment rather than prevention of malaria.

The standard dose of mefloquine is 250 mg. The new regimen consists of a single dose of mefloquine (starting one week before travel) and continued weekly during travel in malarious areas and for 4 weeks after the person leaves the malarious area.[7,8] Children over 30 lbs should take between one fourth and a full tablet every week, depending on their weight.

Persons planning travel to any country having malaria risk should discuss the risks and benefits of antimalarial medications with their personal physicians or local travel clinic. Further information may also be obtained by calling the CDC malaria hotline at 404-332-4555.

International travel continues to increase yearly.[8] The tourist industry is projected to be the largest industry in the world by the year 2000. Physicians who provide advice to travelers need to remain updated on the frequently changing epidemiology and chemoprophylaxis of Malaria.

Table 4.–Advantages and disadvantages of antimalarials.*

Drug	Advantage	Disadvantage
Chloroquine	P vivax, ovale, malariae safety in pregnancy	P falciparum resistance pruritus in blacks
Proguanil	safety (in pregnancy)	limited efficacy
Pyrimethamine/ Sulfadoxine (Fausidar)	self-treatment	P falciparum resistance slow action Stevens Johnson Syndrome (1:25-50,000)
Pyrimethamine/ dapsone	Chloriquine resistent P falciparum sensitivity	? efficacy (P vivax) marrow suppression
Doxycycline	Chloroquine resistant P falciparum sensitivity	GI upset photosensitization
Mefloquine	efficacy	contraindications neuro-psych changes
Primaquine	P vivax, P ovale liver phase, useful for long stays in selected areas	G6PD deficiency resistance (10-30% especially in SE Asia)

* Adapted Keystone JS. Travel Medicine Update, Seattle, Wash, 1989.

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References

1. Centers for Disease Control Malaria Surveillance. US Department of Health and Human Services, Annual Summary. 1987.
2. Jong EC. Travel-related infections: Prevention and treatment. *Hospital Practice*. 1989;145-171.
3. Steffens R, et al. Health problems after travel to developing countries. *J Infect Dis*. Dis 1987;156:84-91.
4. Lobel HA. Malaria and use of prevention measures among United States travelers. Travel Medicine Proceedings of the First Conference on International Travel Medicine; 1988; Zurich, Switzerland; pp. 81-89.
5. Moran JS, Bernard KW. The Spread of Chloroquine-resistant malaria in Africa: Implications for travelers. *JAMA*. 1989;262(2):245-249.
6. Recommendations for the prevention of malaria among travelers. *MMWR*. 1990;39:1-9.
7. CDC Revised Dosing Regimen for Malaria. Prophylaxis with Mefloquine. *MMWR*. Sept. 14, 1990, p. 630.
8. Lobel HO, Bernard KW, Williams, SL, et al. Effectiveness and tolerance of long-term malaria prophylaxis with mefloquine: Need for a better dosing regimen. *JAMA*. 1991;265:361-364.
9. World Travel Organization. Yearbook 37; Madrid, Spain.
10. Lackritz EM, Lobel HO, Howell BJ, et al. Imported Plasmodium falciparum malaria in American travelers to Africa: Implications for prevention strategies. *JAMA*. 1991;265:383-384.❑

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Human ehrlichiosis diagnosed in Wisconsin

Ian Gilson, MD, and Paula Jones, MD, Milwaukee

A man developed a febrile illness shortly after he returned to Wisconsin from Florida, where he had received tick bites. This illness was associated with a rash, thrombocytopenia, leukopenia, and elevated hepatic enzymes, and it resolved on doxycycline. Serologic studies confirmed ehrlichiosis, a tick-borne rickettsial intraleukocytic infection endemic to the Southeastern United States. This case expands the spectrum of tick-borne illnesses that must be considered by Wisconsin clinicians. *Wis Med J* 1991;90(5):219-221.

Ehrlichiosis is a tick-borne rickettsial illness of canines caused by an intraleukocytic rickettsia, Ehrlichia canis, which has only recently been described in humans.[1,2] The etiologic agent of human ehrlichiosis has not as yet been identified, but it is thought to be a rickettsia identical or closely related to Ehrlichia canis, and the diagnosis is based on a rise in titer to Ehrlichia canis. The range of human ehrlichiosis has been considered to extend across the Southeastern and South Central United States.[3] We describe the first case of ehrlichiosis to be diagnosed in Wisconsin.

Case report

A 40-year-old male herpetologist was seen in Milwaukee, July 6, 1990, following a 4-day fever to 40°C, shaking chills, myalgias, arthralgias, nausea, headache, photophobia, and right subcostal pain. From June 25 until June 30, he had been doing alligator surveying in central Florida pinelands and had received multiple tick bites. He had been well prior to his return from Florida.

Dr Gilson and Dr Jones are with Department of Medicine at the Sinai Samaritan Medical Center, and the University of Wisconsin Medical School's Milwaukee Clinical Campus. Address reprints to: Ian Gilson, MD, Internal Medicine Specialties, 788 N Jefferson, Milwaukee, WI 53202. Copyright 1991 by the State Medical Society of Wisconsin.

Physical examination revealed a moderately ill patient having shaking chills. His oral temperature was 37.7°C, blood pressure 98/64 mm, and pulse 92 beats per minute. The results of his fundoscopic examination were normal, and his neck was supple. He had generalized muscle tenderness, a violaceous, blanching maculopapular rash on his back and chest, and an erythematous papule at the site of a tick bite on his left wrist. There was no heart murmur, hepatosplenomegaly, or lymphadenopathy.

The hemoglobin was 14.9g/dL, the white cell count was 4000/mm^3, and the platelet count was 140,000/mm^3. The white blood cell differential showed 82% polymorphonuclear cells, 8% band forms, 7% lymphocytes, 2% mononuclear cells, and 1% basophils. The erythrocyte sedimentation rate was 10 mm per hour. The serum aspartate aminotransferase was 65 IU/L (normal, less than 36 IU/L), the alanine aminotransferase, 75 IU/L (normal, less than 35 IU/L), the creatine kinase, 129 IU/L (normal, less than 192 IU/L), and the alkaline phosphatase, 73 IU/L (normal, less than 135 IU/L). A thick blood smear for malaria and babesia was negative. A hepatitis serologic screen was negative for hepatitis A and B. Two bacterial blood cultures showed no growth. The urinalysis showed specific gravity of 1.030, was negative for protein and blood, and contained 1 to 2 leukocytes per high power field. A roentgenogram of the chest revealed nothing abnormal.

The patient was treated with doxycycline 100 mg every 12 hours for 10 days, oral fluids, and ibuprofen. Within 2 days, he became afebrile and the myalgias resolved, and over the next several weeks his fatigue and headache slowly improved. The rash on the chest cleared rapidly, and the rash on the back resolved more gradually. The platelet count declined to a nadir of 131,000/mm^3 on July 9, and increased to 203,000/mm^3 on July 23. The absolute neutrophil count decreased to 1,596/mm^3 on July 9, and returned to normal on July 23. The absolute lymphocyte count increased from a nadir of 320/mm^3 on July 6 to 2,896/mm^3 on July 23. The alanine aminotransferase increased to 128 IU/L on July 9, and then decreased to 23 IU/L on July 23. No cytoplasmic inclusion bodies were seen on the peripheral blood smears. Paired sera were collected on July 9 (acute) and July 23 (convalescent). Acute and convalescent indirect immunofluorescence titers in serum for Babesia microti and Rickettsia rickettsii were negative. The acute indirect fluorescent antibody titer for Ehrlichia canis was 1:64, and the convalescent titer was 1:256. This increase in titer was considered diagnostic for acute ehrlichiosis.

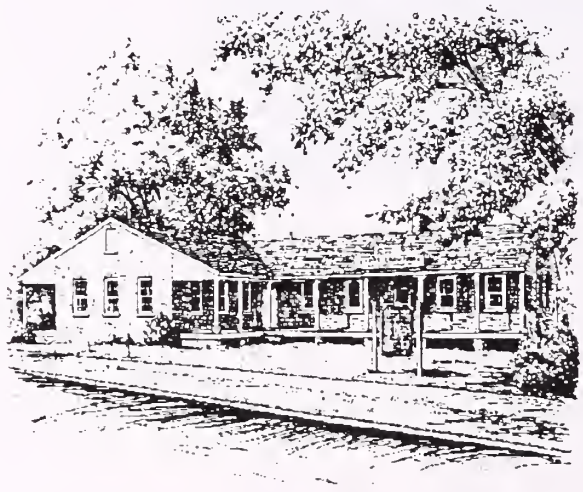
Discussion

This patient showed typical features of ehrlichiosis, including a history of tick bites followed by a severe influenza-like illness, leukopenia, thrombocytopenia, abnormal hepatic enzymes, and a four-fold rise in antibody titer to Ehrlichia canis.[4,5] Ehrlichiosis resembles Rocky Mountain spotted fever but is less likely to present with a rash, present in from 12% to 47% of cases of ehrlichiosis[5-7] and in 88% of cases of Rocky Mountain spotted fever.[8] These two rickettsial illnesses may require paired serologic

testing for differentiation, but both should respond well to tetracycline derivatives,[5,9] which was the case for our patient. Prompt institution of tetracycline therapy may be critical for a successful outcome in both Rocky Mountain spotted fever, which has a mortality rate of 4% to 8%,[8] and ehrlichiosis, which may have a mortality rate as high as 5%.[5] The rapid defervescence in our patient, occurring within 48 hours of institution of doxycycline, was characteristic of ehrlichiosis. Although he was exposed to the ehrlichiosis pathogen in Florida, a state from which several cases have been previously reported [10] (and verbal communication, J. Dawson, of the Centers for Disease Control, November 1990), he showed clinical manifestations only after returning to Wisconsin, and an occupational and travel history was essential to arrive at an accurate diagnosis and administer appropriate therapy. Even in areas where ehrlichiosis is common, diagnosis often proves to be elusive.[6]

Wisconsin has been included in the Centers for Disease Control testing program for ehrlichiosis; in 1988, there were 15 serum specimens submitted from Wisconsin for Ehrlichia canis serology, all of which were nonreactive.[5] To our knowledge, the current case is the first serologically confirmed case of human ehrlichiosis in Wisconsin (verbal communication, J. Kazmierczak, Wisconsin Division of Health, November 1990). Wisconsin is an endemic area for Lyme disease, another tick-borne infection, and this case adds to the spectrum of tick-borne illnesses which must be considered by Wisconsin clinicians.

In this case, ehrlichiosis was suspected within hours of presentation, despite the prior lack of awareness of this condition by the primary clinician involved in his care (IG), and the lack of any reference to ehrlichiosis in the most current medical textbooks.[11] The history of tick bite and febrile presentation led to a CD-ROM search of Consult, an electronic textbook by Scientific American Medicine, and an on-line Medline search using Grateful Med (National Library of Medicine), which captured the initial 1987 cases described by Maeda[1] and Fishbein[2] and led to a presumptive diagnosis of ehrlichiosis nearly 4 months before serologic confirmation, with prompt institution of appropriate therapy. Immediate access to current electronic databases by prac-



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Acknowledgement
We would like to thank Jacqueline Dawson of the Viral and Rickettsial Division of the Center for Disease Control, Atlanta, for reviewing this manuscript.

References

1. Maeda K, Markowitz N, Hawley RC, et al. Human infection with Ehrlichia canis, a leukocytic rickettsia. *N Engl J Med*. 1987;316:853-856.
2. Fishbein DB, Sawyer LA, Holland CJ, et al. Unexplained febrile illnesses after exposure to ticks: infection with an Ehrlichia? *JAMA*. 1987;257:3100-3104.
3. Rocky Mountain spotted fever and human ehrlichiosis—United States, 1989. *MMWR*. 1990;39:281-284.
4. Conrad ME. Ehrlichia canis: a tick-borne rickettsial-like infection in humans living in the southeastern United States. *Am J Med Sci*. 1989;297(1):35-37.
5. Eng TR, Harkness JR, Fishbein DB, et al. Epidemiologic, clinical, and laboratory findings of human ehrlichiosis in the United States, 1988. *JAMA*. 1990;264:2251-2258.
6. Fishbein DB, Kemp A, Dawson JE, et al. Human ehrlichiosis: prospective active surveillance in febrile hospitalized patients. *J Infect Dis*. 1989;160(5):803-809.
7. Rohrbach BW, Harkess JR, Ewing SA, et al. Epidemiologic and clinical characteristics of persons with serologic evidence of E. canis infection. *Am J Public Health*. 1990;80(4):442-445
8. Helmick CG, Bernard KW, D'Angelo LJ. Rocky Mountain spotted fever: clinical, laboratory, and epidemiological features of 262 cases. *J Infect Dis*. 1984;84:480-488.
9. Human ehrlichiosis—United States. *MMWR*. 1988;37(17):270, 275-277.
10. McDade JE. Ehrlichiosis—a disease of animals and humans. *J Infect Dis*. 1990;161(4):609-617.
11. Woodward TE. Rickettsial diseases. In: Harrison's Principles of Internal Medicine, 12th ed. New York, NY: McGraw Hill;1991:753-763.
12. Drapkin MS. Experimental procedure-retrieved via Medline-used to treat deathly ill child. From the National Library of Medicine. US Department of Health and Human Services, Public Health Service, National Institutes of Health; July/August 1990:1-3.❑

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Electromagnetic induced shock wave therapy of ureteral calculi

J. Vincent Thomalla, MD; Ian L. Goldman, MD; Michel Y. Roy, MD; Michael C. Seelen, MD; and David A. Eisberner, RN, Marshfield

Between March 1989 and July 1990, 86 patients with ureteral stones were treated with electromagnetic induced extracorporeal shock wave lithotripsy at our facility, of which 77 were available for follow-up. Sixty-one of the patients were male, 16 were female, and the average age was 53.8 ± 16.0 (11-84). Seventy-four of the patients were treated with intravenous sedation. One patient required general anesthesia and two other patients requested no sedation.

Sixty-four of 77 (83%) patients were stone free after therapy, 59 of 77 (77%) after a single treatment, and 5 of 9 (56%) after a second treatment. Thirteen patients were hospitalized post therapy, however, 6 had been hospitalized pretreatment because of pain or obstruction. Four major complications were encountered: hematoma (1), ureteral stricture (1), urinary extravasation (1), and proximal stent migration (1).

There were no statistically significant differences between stone free and non-stone free patients when comparing for sex, age, stone size, number of shocks, maximum kilovoltage, or duration of symptoms pretreatment. The patients who had unsuccessful treatment, however, were noted to have a significantly greater incidence of distal stones (69% v 39%) (P<.05). *Wis Med J* 1991;90(5):223-225.

Since the widespread clinical application of shock wave therapy for the disintegration of renal calculi in the early 1980s, many refinements have been made in extracorporeal shock wave lithotripsy. Second generation lithotriptors employing bath-free treatment mediums, enhanced imaging systems and refinements in shock wave production have allowed for virtual complete treatment capabilities of calculi lodged anywhere along the urinary tract.

Herein, we present our experience with the treatment of ureteral calculi with electromagnetic extracorporeal shock wave lithotripsy.

From the Department of Urology at the Marshfield Clinic. Reprint requests to: J. Vincent Thomalla, MD, 1000 N Oak Ave, Marshfield, WI 54449. Copyright 1991 by the State Medical Society of Wisconsin.

Materials and methods

Between March 1989 and July 1990, 86 patients with ureteral stones were treated with the Siemens Lithostar (Siemens Medical Systems Inc, Iselin, NJ) unit at our facility. Of these, 77 patients were available for complete follow-up. Of the 77 patients, 61 were male and 16 female, with an average age of 53.8 ± 16, (range 11-84). The position of the stone at the time of presentation for treatment revealed: ureteropelvic junction 10%, proximal ureter 14%, mid ureter 32%, and distal ureter 44%. Forty-three (56%) had histories of previous stones. Stone size was, minimum x maximum in millimeter, 5.0 ± 2.5 x 7.8 ± 3.8. The average number of shocks and maximum kilovoltage used were 5535 ± 1789 (1400-8000) and 18.3 ± .9 (15.1-19.0) respectively.

Although no uniform criteria had been established, 15 patients underwent pretreatment ureteral stenting either because of severe pain or complete ureteral obstruction. Two patients could not be stented and required percutaneous nephrostomy placement for resolution of complete ureteral obstruction. These two patients had stents placed subsequent to therapy at the time of nephrostomy removal. The majority of patients were treated in the supine position (51%), however, prone (27%), reverse supine (12%), and reverse prone (5%) positions were also used. Multiple positions were required for four patients to best target the stone and minimize patient discomfort. Seventy-four of the patients were treated with intravenous sedation (Valium and morphine). One patient, an 11-year-old, required general anesthesia and two other patients requested no sedation.

Results

Sixty-four of 77 patients (83%) were stone free after therapy, 59 of 77 after a single treatment (77%), and 5 of 9 after a second treatment (56%). A stone free state was assessed by comparing post treatment films with pretreatment films. Of the successful cases, 92% were stone free 3 months after the treatment. Of the 17 patients who were stented, 14 became stone free, 12 of whom required stent removal before stone passage. Of the two patients with nephrostomy tubes, both became stone free but required two treatments. Thirteen patients were hospitalized after their therapy, and 6 had been hospitalized prior to treatment because of pain or obstruction. Four major complications arose out of therapy: hematoma (1), ureteral stricture (1), urinary extravasation (1) and proximal stent migration (1).

When comparing stone free with non-stone free patients, no statistical differences were apparent for sex, age, stone size, number of shocks,

maximum kilovoltage or duration of symptoms prior to treatment (Table). The position of the stone within the ureter, however, demonstrated that 9 of 13 patients who did not become stone free had a distal ureteral stone, whereas 25 of 64 who were stone free had a distal ureteral stone which was significant at a P-value of less than .05 (by x^2).

Discussion

The introduction of extracorporeal shock wave lithotripsy (ESWL) into the clinical management of urinary tract calculi has revolutionized the treatment of stone disease in less than a decade. In that period of time, many changes have occurred in the management of stones using ESWL as well.[1-3] In a similar fashion, the treatment of ureteral stones with ESWL has evolved over time. Initial attempts at treating ureteral calculi with the Dornier HM3 lithotriptor (Dornier Medical Systems Inc, Marietta, Ga) were limited because of the location of the fluoro units in relationship to the patient gantry. This severely limited treatment of stones located over the sacroiliac joints and the pelvis.[4] As a result, many advocated active proximal migration of the stone into the upper ureter or into the renal pelvis itself so that the stone could then be treated with ESWL.[5] Other nonsurgical treatment modalities flourished as a result of this hiatus in ESWL effectiveness. Ureteroscopy, both rigid and flexible, combined with direct basketing, crushing or disintegration of the calculus (electrohydraulic, ultrasound and pulse dye laser) spread rapidly to fill this gap.[6-8]

Refinements in design of second generation lithotriptors, however, have resolved some of the earlier limitations to therapy such that the entire urinary tract can now be treated. The Siemens Lithostar is one of these second generation units and has been successfully used for the treatment of renal, ureteral and vesical calculi.[9-11] The Lithostar unit is uniquely designed so as to give the maximal capability of positioning the patient such that the stone can be imaged and treated. Although the Lithostar unit has not made ESWL analgesia free, the need for hospitalization after therapy has been limited making ESWL truly an outpatient procedure. The use of the electromagnetic shock wave generator has resulted in lower maximal kilovoltage that can be delivered, which has necessitated more shocks to achieve stone disintegration, leading to the drawback of longer treatment times.

Recently, the Lithostar unit has been modified so that more shocks per minute can be delivered (120 shocks/min from 90 shocks/min). Currently, the maximum kilovoltage that can delivered in the United States is 19 kV, although in Europe it is 23 kV. Should increases in the maximum kilovoltage be allowed in the future, then treatment times may be decreased, but at the expense of increased anesthesia coverage.

Prediction of those patients who will be successfully treated by lithotripsy has not been feasible. Other than stone position within the ureter, no other parameter has been helpful in identifying those patients who have a low potential for successful therapy with the Lithostar unit. As more experience is gained, other factors may become evident that may be able to make this discrimination.

Two areas that have not been addressed completely by this study, or others concerning the treatment of ureteral calculi are: 1) Should stents be used routinely? 2) When should ESWL intervention be used for treatment of ureteral stones?

The use of ureteral stents for the management of obstructed ureters has had much clinical success and have been used frequently for this purpose in ESWL management of large upper tract stones to provide for an unobstructed ureter in the event of fragment impaction within the ureter following therapy. What has not been clearly shown, however, is whether routine stenting of even nonobstructing stones would have a higher stone free success rate.[5,9,11]

Stone free and non-stone free patients compared for seven variables.

	Stone free		Non-stone free
age	53.2 ± 15.2	NS	65.5 ± 20.3
sex	female 87% male 82%	NS NS	female 12.5% male 18%
stone size (maximum x mimimum in mm)	4.9 ± 2.7 x 7.4 ± 3.6	NS	5.2 ± 1.6 x 9.7 ± 4.5
No. of shocks	5,347 ± 1,863	NS	6,462 ± 967
maximum kV	18.1 ± 1.0	NS	18.9 ± 2
symptom duration (before treatment, in days)	36.0 ± 61.2	NS	68.4 ± 78
position in ureter	*UPJ PROX MID DIS* *7 7 25 25*	*P<.05 (by x^2)*	*UPJ PROX MID DIS* *0 4 0 9*

We have placed stents in 17 patients, of whom 14 became stone free (82%), compared to 45 of 60 (75%) patients who became stone free without a stent in place, which was not statistically significant (NS).

Of interest was that, of the 14 stented patients who became stone free, 12 of them achieved that state after the stent had been removed, suggesting that the stent itself did not affect the direct passage of the stone, but rather modified the physiology of the ureter so that subsequent stone passage was enhanced after the stent's removal. Theoretically, this may be accomplished by impaired peristaltic activity of the ureter while the stent is in place which results in mild ureteral dilatation. With removal of the stent, the stone can be more easily propagated through the distally dilated ureter as the peristaltic activity becomes effective again.[12,13]

This raises the question as to whether stenting alone without additional therapy could be used for the management of single small ureteral stones. The stent may also allow for an expansion chamber further facilitating stone breakage and subsequent passage.[14] The drawback to the use of stents in any patient is the obvious need for instrumentation of the ureter with its attendant risks and the possible greater need for anesthesia coverage.

The other area to be looked at critically is: When in the course of ureteral calculus passage should intervention of any type be considered appropriate? Prior to the advent of ESWL and ureteroscopy techniques, the vast majority of stones were managed conservatively with expectant therapy with open procedures being employed when the stone was deemed too large to pass or was causing complete obstruction of the kidney or was associated with infection. Other stones that were managed conservatively in the proximal ureter were than basketed from the distal ureter after they had been given ample opportunity to pass spontaneously. With ESWL, however, one can treat stones very successfully as soon as they present clinically.

The question that arises is: How long should conservative management delay the use of ESWL? Certainly, as the stone size goes up the potential for spontaneous passage decreases, but even small 1-2 mm stones can produce severe symptoms requiring hospitalization (with its expense and loss of work time). This has been contrasted against the over use of ESWL (the cost of which is not negligible) for treatment of stones that would pass spontaneously without ESWL or the need for supportive hospitalization. The worse situation to be avoided would be the setting where conservative management fails which has required prolonged hospitalization and still requires ESWL for treatment of the stone, thus in effect doubling the price of therapy. We have used ESWL therapy for ureteral stones in patients where hospitalization has taken place and then have treated the stone as soon as possible in order to allow them to become stone free outside the hospital thus minimizing the overall cost of therapy. Other asymptomatic patients have generally been referred from outside with known stones such that by the time they are scheduled for treatment, they have had some opportunity for spontaneous stone passage. These two issues have yet to be resolved.

References

1. Chaussy CG , Fuchs GJ. Current state and future developments of noninvasive treatment of human urinary stones with extracorporeal shock wave lithotripsy. *J Urol* part 2. 1989;141:782.
2. Lingeman JE, Newman D, Mertz JHO, et al. Extracorporeal shock wave lithotripsy: the Methodist Hospital of Indiana experience. *J Urol* 1986;135:1134.
3. Constantinides D, Recker F, Jaeger P, et al. Extracorporeal shock wave lithotripsy as monotherapy of staghorn renal calculi: Three years experience. *J Urol.* 1989;142:1415.
4. Jenkins AD, Gillenwater, JY. Extracorporeal shock wave lithotripsy in the prone position: Treatment of stones in the distal ureter or anomalous kidney. *J Urol.* 1988;139:911.
5. Lingeman JE, Shirrell WL, Newman D, et al. Management of upper ureteral calculi with extracorporeal shock wave lithotripsy. *J Urol.* 1987;138:720.
6. Segura JW. The role of percutaneous surgery in renal and ureteral stone removal. *J Urol.* Part 2, 1989;141:780.
7. Denstedt JD, Clayman RV. Electrohydraulic lithotripsy of renal and ureteral calculi. *J Urol.* 1990;143:13.
8. Dretler SP, Watson G, Parish JA, et al. Pulsed dye laser fragmentation of ureteral calculi: Initial clinical experience. *J Urol.* 198;137:186.
9. Grace PA, Gillen P, Smith JM, et al. Extracorporeal shock wave lithotripsy with the lithostar lithotriptor. *Brit J Urol.* 1989;64:117.
10. Vandeursen H, Baert L. Extracorporeal shock wave lithotripsy monotherapy for bladder stones with the second generation lithotriptor. *J Urol.* 1990;143:18.
11. Netto NR, Premos GC, Claro JFA. In situ extracorporeal shock wave lithotripsy for ureteral calculi. *J Urol.* 1990;144:243.
12. Weis RM. Physiology and pharmacology of the renal pelvis and ureter in Campball's urology. Edited by Walsh PC, Gittes RF, Perlmutter AD, et al. Philadelphia, WB Sauders Vol 1, Chapt 3, 1986;106-117.
13. Payne SR, Ramsy JWA. The effects of Double J Stents on renal pelvic dynamics in the pig. *J Urol.* 1988;140:637.
14. Mueller SC, Wilbert D, Theuroff JW, et al. Extracorporeal shock wave lithotripsy of ureteral stones: Clinical experience and experimental findings. *J Urol.* 1986;135:831.❑

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Kawasaki syndrome in Wisconsin

Anna Marie B. Windsor, MD; Wendy L. Schell, MS;
and Jeffrey P. Davis, MD, Madison

We reviewed cases of Kawasaki syndrome reported to the Wisconsin Division of Health and occurring in Wisconsin residents with illness onsets between 1982 and 1989. Of 164 reports, there were 73 confirmed cases that met the Centers for Disease Control case definition criteria for Kawasaki syndrome, 87 probable cases, and four non-cases. Confirmed cases were reported in residents of all five Wisconsin public health regions. The Wisconsin data was demographically similar to national data: 80% of the cases occurred in children younger than 5 years old, the mean annual incidence rate was highest in children 12 to 23 months of age, males were affected more often than females, and the incidence rate was higher among non-white children than among white children. Coronary artery aneurysms occurred in 16% of the patients with confirmed cases. Males developed aneurysms significantly more often than females, and aneurysm formation did not correlate with age. Kawasaki syndrome continues to occur in Wisconsin, and complete and accurate reporting of the disease will enhance the understanding of its natural history and etiology. *Wis Med J* 1991;90(5):227-231.

KAWASAKI SYNDROME is an acute, systemic febrile illness occurring most frequently in children younger than 5 years old and rarely seen after age 8.[1] While usually a self-limited condition, severe and fatal complications can occur, primarily associated with cardiac involvement.[1] Kawasaki syndrome was initially reported in Japan in 1967, and in the United States in 1976.[1,2] Despite years of investigation in the United States, Japan, and elsewhere, the etiology of Kawasaki syndrome remains unknown and enigmatic; however, an infectious agent or an immune response to an infection is the most likely etiology. Antecedent respiratory illness, rug shampooing, house dust mites, and residence near water have all been associated with the development of Kawasaki syndrome in various case control studies.[3-7] Each of these factors, however, has been shown to have no association with Kawasaki syndrome in other case control studies.[8-10] There has been no evidence of person-to-person transmission of Kawasaki syndrome.

In this report, we summarize the descriptive epidemiologic features and reported complications associated with Kawasaki syndrome in Wisconsin residents since 1982. Kawasaki syndrome has been officially reportable in Wisconsin since May 1, 1984.

Materials and methods

Reports of Kawasaki syndrome are received by the Wisconsin Division of Health (DOH) on the Acute and Communicable Diseases Case Report form (DOH 4151). Since 1985, reporting physicians have been requested to complete a follow-up form that includes more detailed information regarding the patient's signs and symptoms, laboratory and other diagnostic tests, and complications.

The diagnosis of Kawasaki syndrome is made on clinical grounds. The case definition developed by the Centers for Disease Control (CDC) requires that fever without other reasonable explanation be present for 5 days or more. In addition, four of the five following criteria must be met: 1) bilateral conjunctival injection; 2) injected lips, fissured lips, injected pharynx, or "strawberry" tongue; 3) erythema of palms or soles, edema of hands or feet, or generalized or periungual desquamation; 4) polymorphous truncal rash without vesicles or crusts; and 5) cervical lymphadenopathy (at least one node 1.5 cm or larger in diameter).[11] In all cases, other likely diagnoses, such as streptococcal disease, must be excluded before the diagnosis of Kawasaki syndrome is made.

We reviewed 164 reported cases of Kawasaki syndrome in Wisconsin residents with onsets between Jan 1, 1982, and Dec 31, 1989. Eighty-six reports included submission of the follow-up form, and information from the follow-up form was used to classify these reports as follows: 73 confirmed cases that met the CDC case definition criteria, 10 probable cases that included insufficient information to confirm the case based on CDC case criteria, and three non-cases that clearly did not meet the case criteria. The three non-cases were deleted from the data base and are not included in this analysis. The follow-up form was not included in 78 reports; 62 of these were submitted between

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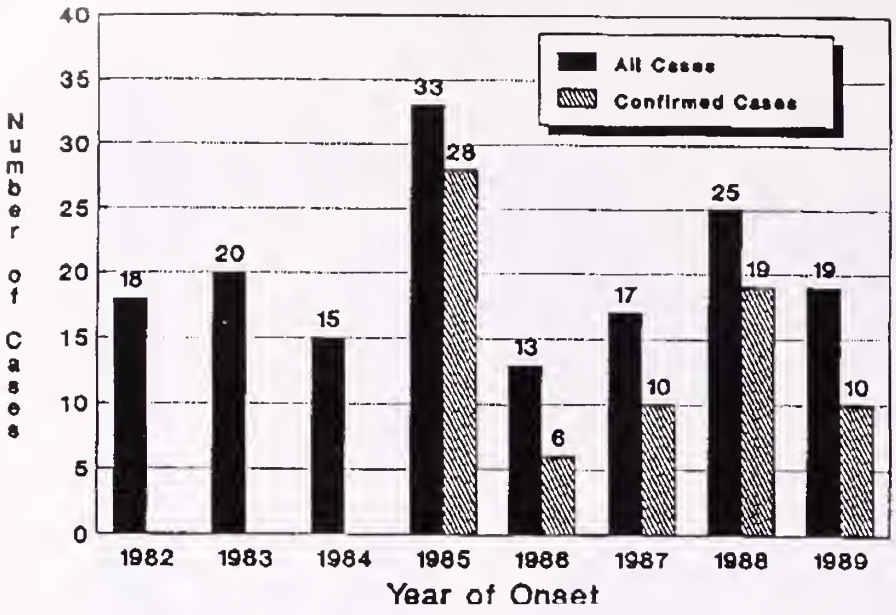

Fig 1.–Kawasaki syndrome reported in Wisconsin residents from 1982 through 1989.

1982 and 1984, before use of the follow-up form began. Of the 78 reports with no follow-up form, 77 were classified as probable cases and one was classified as a non-case. Thus, the following analysis includes a total of 160 reported cases of Kawasaki syndrome; 73 (46%) confirmed cases and 87 (54%) probable cases. Rates are based on Wisconsin Population Projections 1980-2020 (Demographic Services Center, Wisconsin Department of Administration, June 1988) with the exception of rates by racial group which are based on 1980 census data (Vital Statistics: Wisconsin).

Results

From 1982 through 1989, an annual mean of 20 cases of Kawasaki syndrome were reported, with a peak of 33 cases reported in 1985 (Fig 1). The mean annual incidence rate for children younger than 5 years old was 4.0 cases/10^5 population.

The mean age among 146 cases of Kawasaki syndrome reported with known age was 3.1 ± 2.6 years (median 2 years, range 2 months to 16 years). Eighty percent of the cases occurred among children younger than 5 years. The mean annual incidence rate was highest in children 12 to 23 months old (6.2 cases/10^5 population), and decreased with increasing age. The age distribution of confirmed cases followed a similar pattern; mean age was 2.7 ± 1.8 (Fig 2). Fifty-six percent of all reported cases were in males and 44% were in females. The male-to-female ratio was 1.3:1 among all cases and 1:1 among confirmed cases only.

Race and ethnic data were included in 148 case reports of Kawasaki syndrome with distribution as follows: 115 (78%) white; 24 (16%) black; 6 (4%) Asian; 1 (1%) American Indian; and 2 (1%) other race. The mean annual incidence rate among children younger than 15 years was 4.5 cases/10^5 in non-white children and 1.3 cases/10^5 in white children. Among children younger than 5 years, the rate was 11.4 cases/10^5 in non-white children and 3.2 cases/10^5 in white children.

In the five Wisconsin public health regions, the highest reported mean annual incidence of Kawasaki syndrome was in the southeastern region where there were 6.1 cases/10^5 children younger than 5 years (Fig 3). The reported mean annual incidence in children younger than 5 ranged from 1.9 to 3.3 cases/10^5 in the other regions. A relative geographic distribution was similar when the incidence of only confirmed cases was determined (Fig 3).

A slight seasonal variation was noted with peak occurrence of Kawasaki syndrome onset during the

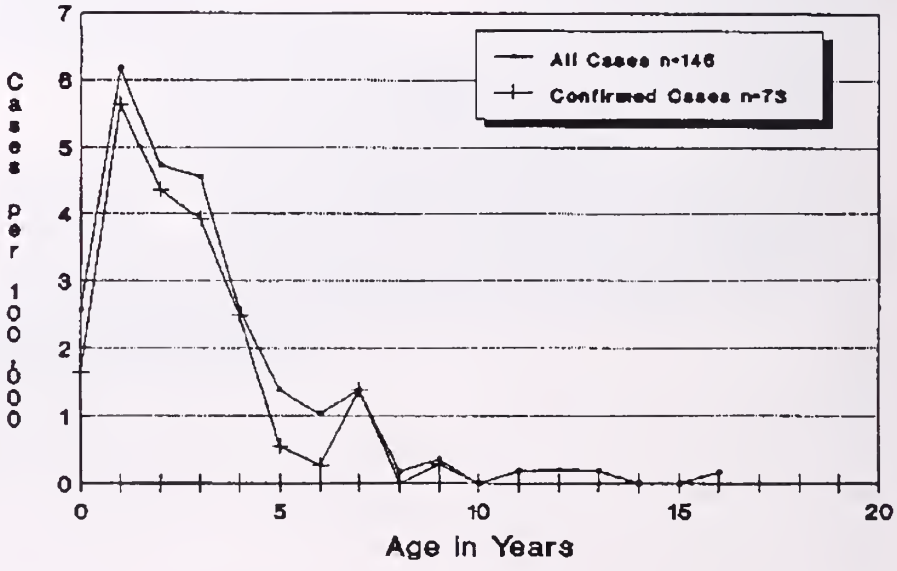

Fig 2.–The mean annual incidence of Kawasaki syndrome by age at onset in Wisconsin, 1982-1989.

winter and spring. Of the 160 total cases reported, 99 (62%) had onsets during December through May. There was less seasonal variation in onset among the 73 patients with confirmed cases; 38 (52%) had onsets December through May.

Of the 73 confirmed cases, 66 reports included data on the presence or absence of complications. The frequency of reported complications was as follows: arthritis, 12 patients (19%); coronary artery aneurysm, 10 (16%); arthralgia, 9 (15%); cardiac arrhythmias, 4 (6%); gallbladder hydrops, 4 (6%); hepatic abnormalities, 4 (6%); myocarditis, 3 (5%); pericardial abnormalities, 3 (5%); and aseptic meningitis, 1 (2%). Among the 73 patients with confirmed cases, 72 (99%) were hospitalized.

No deaths were reported on DOH form 4151 among the 160 confirmed and probable cases. Death certificate review of Wisconsin residents for the years 1982 through Sept 1, 1990, however, revealed two deaths associated with Kawasaki syndrome. One occurred as a consequence of Kawasaki syndrome acquired in 1980, before the period of this study. The other death occurred in 1984 in a Minnesota hospital as a consequence of Reye syndrome acquired during aspirin therapy for Kawasaki syndrome. Because no DOH form 4151 reporting the onset of this illness was received, the case is not included in our data base.

Data regarding coronary artery aneurysm formation were available for 62 of the confirmed cases. Significantly more males (9/29) developed coronary artery aneurysms than females (1/33) (odds ratio 14.4; 95% confidence interval=1.7, 650.3; p=0.003). Age and race had no significant correlation with aneurysm formation. Among children who developed aneurysms, the mean maximum measured platelet count was 943,250 ± 505,495; the mean among children who did not develop aneurysms was 653,447 ± 233,406 (p=0.12, Kruskal-Wallis test for two groups). The mean maximum erythrocyte sedimentation rate did not correlate with aneurysm formation. Sufficient data on salicylate and intravenous immunoglobulin management were not available to further evaluate trends in coronary artery aneurysm formation.

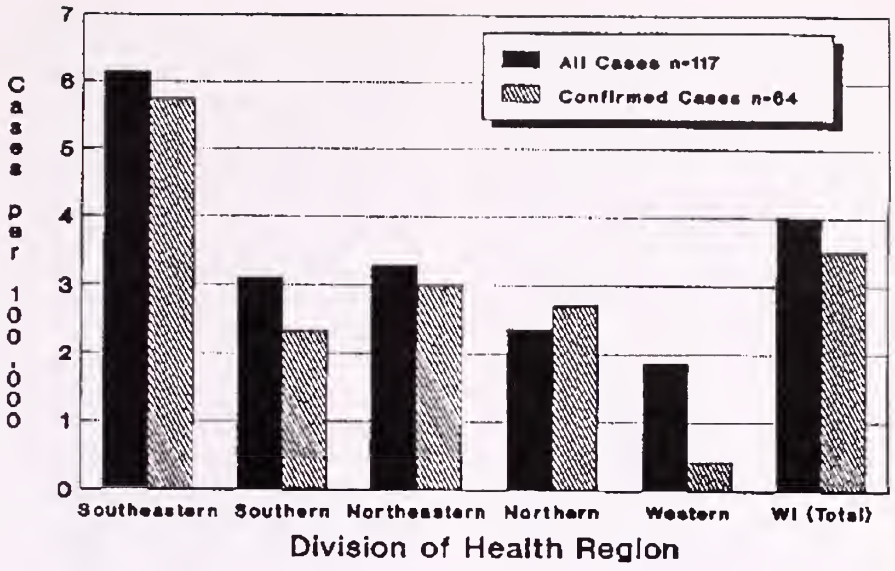

Fig 3.–Mean annual reported incidence of Kawasaki syndrome in children younger than 5 years by Division of Health region in Wisconsin, 1982-1989.

Discussion

These DOH surveillance data for Kawasaki syndrome are based on passively submitted reports by physicians and other providers. The accuracy of diagnosis was apparently high since 73 (96%) of the 76 case reports with provision of complete clinical information met the CDC case criteria.

It is likely that unreported cases of Kawasaki syndrome occurred in Wisconsin residents during the 8-year period, but the number of such cases may well be small. The mean annual reported incidence rate of 4.0 cases/10^5 children younger than 5 years derived from passive surveillance data in Wisconsin is similar to rates derived from active surveillance data for comparably aged children elsewhere in the United States: 5.95 cases/10^5 children in the Chicago area from 1979 to 1983;[12] 5.6 cases/10^5 children in the Rochester, NY, area prior to a 1979 outbreak;[3] 4.6 cases/10^5 children in Massachusetts after a 1980 outbreak;[3] and 4.5 cases/10^5 in Colorado prior to a 1982 outbreak.[7]

The relatively higher number of cases reported in 1985 and 1988, 33 and 25 respectively, may reflect the 2- to 4-year periodicity of Kawasaki syndrome occurrence noted elsewhere in the United States.[13]

The age distribution among reported Kawasaki syndrome cases in Wisconsin is similar to that reported nationally. Cases are not detected during the first month of life, and the incidence peaks between 12 and 23 months of age, decreasing with increasing age to become uncommon after middle childhood.[14] The median case age reported nationally is 2.3 years, and more than 80% of cases occur in children younger than 5 years.[15,16] The gender distribution, however, differs slightly. A greater male predominance has been reported nationally with a male-to-female ratio of 1.5:1.[15]

Nationally, the incidence rate of Kawasaki syndrome is highest in children of Asian decent, intermedi-

ate in black children, and lowest in white children (Asian:white, 8.8:1; black:white, 1.7:1).[16] Because of the small number of reported cases among Wisconsin children of Asian descent, the data for this group could not be analyzed separately. The incidence of Kawasaki syndrome among non-white children in Wisconsin is approximately 3.5 times greater than among white children. Furthermore, the relatively high incidence of Kawasaki syndrome in the southeastern region of the state may, in part, be correlated with the higher incidence rate among black children because 92% of black residents in Wisconsin live in the southeastern region. Unfortunately, the 1980 census data is the only denominator data available for calculation of race specific rates by age. Any significant change during the ensuing decade in the racial composition of the population of children under 5 years in Wisconsin could affect these rates and observations.

Information regarding coronary artery aneurysm formation was available only from reports of confirmed cases in Wisconsin. Previous national reports of the frequency of coronary artery aneurysm formation among randomly selected cases vary from 16% to 25%.[12,17,18] The frequency of reports of coronary artery aneurysms among case patients in Wisconsin (16%) falls in the low end of that range, suggesting that reports in Wisconsin may reflect a full spectrum of Kawasaki syndrome rather than a bias toward more serious cases.

Despite the small sample size, male gender was associated significantly more often with coronary artery aneurysm formation. There is no clear explanation for this difference and treatment data was not requested. The original list of risk factors for coronary artery aneurysm formation developed in Japan included male gender.[19] In a study of Kawasaki syndrome in the Chicago area, a higher rate of coronary artery abnormalities was reported in boys when compared to girls.[12] Other investigators, however, have found no significant association of aneurysm formation with gender.[17,20] Unlike many studies which found an increased risk of aneurysm formation with decreased age,[12,17,19,20] the Wisconsin data demonstrate no association between age and aneurysm formation. The non-association between age and aneurysm formation was reported in one previous study.[21]

We noted a non-significant trend between an increase in the mean maximum measured platelet count and the occurrence of coronary artery aneurysm, although data were limited by the small number of cases developing aneurysms and absence of data on preventive treatment with salicylate and intravenous immunoglobulin. The association of increased maximum platelet count with coronary artery aneurysm formation has been noted in one previous study,[20] but not in another.[21]

Kawasaki syndrome case fatality rate reported by national surveillance has declined from 1% to 2% during the late 1970s to 0.7% between 1982 and 1985.[22] With increased awareness of the disease and improved treatment, including aspirin therapy and intravenous immuno globulin, it is likely that case fatality has decreased even further during the late 1980s.[13,23] We reviewed death certificates from 1982 through Sept 1, 1990, because most deaths secondary to Kawasaki syndrome occur between 20 and 40 days after the onset of illness,[13] which is after the period during which cases are likely to be reported to the DOH. The death certificate review revealed one case ineligible for this study because it occurred prior to 1982, and one case which probably could have been reported to the DOH, but was not reported, and occurred before Kawasaki syndrome was officially reportable. The review revealed no deaths among the 160 cases in our data base. The Kawasaki syndrome case fatality rate in Wisconsin is, therefore, likely to be less than 1%.

In conclusion, Kawasaki syndrome is an infrequently fatal condition that continues to cause serious complications. Timely diagnosis with appropriate management and treatment are essential.[13] Observations differ regarding the epidemiologic features of and risk factors for the disease, thus continued efforts to obtain accurate and complete information through reports to local public health agencies and the Wisconsin Division of Health must be continued. Analysis of surveillance data from Wisconsin and other states can facilitate greater understanding of the natural history of Kawasaki syndrome, as well as preventive mechanisms. Surveillance data can also be of great value in facilitating the ultimate identification of the etiologic agent of Kawasaki syndrome, which currently remains unknown.

References

1. Kawasaki T, Kosaki F, Okawa S, et al. A new infantile acute febrile mucocutaneous lymph node syndrome (MLNS) prevailing in Japan. *Pediatrics.* 1974;54:271-276.
2. Melish M, Hicks R, Larson E. Mucocutaneous lymph node syndrome in the United States. *Am J Dis Child.* 1976;130:599-607.
3. Bell DM, Brink EW, Nitzkin JL, et al. Kawasaki syndrome: Description of two outbreaks in the United States. *N Engl J Med.* 1981;304:1568-1575.
4. Dean AG, Melish M E, Hicks R, et al. An epidemic of Kawasaki syndrome in Hawaii. *J Pediatr.* 1982;100:552-557.
5. Fatica NS, Ichida F, Engle MA, et al. Rug shampoo and Kawasaki disease. *Pediatrics.* 1989:84:231-234.
6. Rauch AM, Kaplan SL, Nihill MR, et al. Kawasaki syndrome clusters in Harris County, Texas, and eastern North Carolina. A high endemic rate and a new environmental risk factor. *Am J Dis Child.* 1988;142:441-444.
7. Patriarca PA, Rogers MF, Morens DM, et al. Kawasaki syndrome: Association with the application of rug shampoo. *Lancet.* 1982;2:578-580.
8. Klein BS, Rogers MF, Patrican LA, et al. Kawasaki syndrome: A controlled study of an outbreak in Wisconsin. *Am J Epidemiol.* 1986;124:306-316.
9. Lin FC, Bailowitz A, Koslowe P, et al.

Kawasaki syndrome: A case-control study during an outbreak in Maryland. *Am J Dis Child.* 1985;139:277-279.
10. Rogers MF, Kochel RL, Hurwitz ES, et al. Kawasaki syndrome: Is exposure to rug shampoo important? *Am J Dis Child.* 1985;139:777-779.
11. Centers for Disease Control: Kawasaki syndrome–United States. *MMWR.* 1983;32:98-100.
12. Shulman ST, McAuley JB, Pachman LM, et al. Risk of coronary abnormalities due to Kawasaki disease in urban area with small Asian population. *Am J Dis Child.* 1987;141:420-425.
13. Shulman ST, Bass JL, Bierman F, et al. Management of Kawasaki syndrome: A consensus statement prepared by North American participants of The Third International Kawasaki Disease Symposium, Tokyo, Japan, December, 1988. *Pediatr Infect Dis J.* 1989;8:663-665.
14. Nihill MR, Feigin RD, Gruber R, et al. Kawasaki disease. In: RD Feigin and JD Cherry. *Textbook of Pediatric Infectious Diseases.* 2nd ed. Philadelphia, PA: WB Saunders; 1987:2137-2165.
15. Rauch AM. Kawasaki syndrome: Issues in etiology and treatment. *Adv Pediatr Infect Dis.* 1989;4:163-182.
16. Bell DM, Morens DM, Holman RC, et al. Kawasaki syndrome in the United States. *Am J Dis Child.* 1983;137:211-214.
17. Nakano H, Uead K, Saito A, et al. Scoring method for identifying patients with Kawasaki disease at high risk of coronary artery aneurysms. *Am J Cardiol.* 1986;58:739-742.
18. Engle MA, Fatica NS, Bussel JB, et al. Clinical trial of single-dose intravenous gamma globulin in acute Kawasaki disease. *Am J Dis Child.* 1989;143:1300-1304.
19. Asai T. Evaluation method for the degree of seriousness in Kawasaki disease. *Acta Paedtr Jpn.* 1983;25:170-175.
20. Ichida F, Fatica NS, Engle MA, et al. Coronary artery involvement in Kawasaki syndrome in Manhattan, New York: Risk factors and role of aspirin. *Pediatrics.* 1987;80:828-835.
21. Koren G, Lavi S, Rose V, et al. Kawasaki disease: Review of risk factors for coronary aneurysms. *J Pediatr.* 1986;108:388-392.
22. Rauch AM. Kawasaki syndrome: Review of new epidemiologic and laboratory developments. *Pediatr Infect Dis J.* 1987;6:1016-1021.
23. Morens DM, Anderson LT, Hurwitz ES. National surveillance of Kawasaki disease. *Pediatrics.* 1980;65:21-25.❑

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- Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors* and AMA *Manual of Style*.
- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
- Authors are responsible for supplying the full and correct names of drugs. Use generic names of drugs, unless the specific trade name of a drug is directly relevant to the discussion. If the author so desires, brand names may be inserted in parentheses.
- Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.
- Provide each author's full name and highest academic degree in the byline. If an author holds two doctoral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

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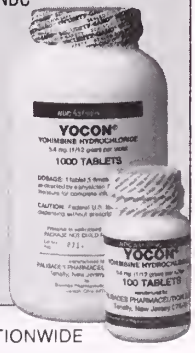
How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Public health

Data-based cancer control programs: a public health response

Judith A. Zvara, MA; Dennis E. Anderson; Patrick L. Remington, MD; and Henry Anderson, MD, Madison

In 1985, the National Cancer Institute (NCI) established cancer objectives for the nation directed towards smoking prevention and cessation, dietary modification, screening for breast and cervical cancer, control of occupational and environmental exposures, and access to state-of-the-art treatment for all persons with cancer.[1] As part of its strategy to implement these objectives, the NCI instituted a 5-year grant program for state health departments to develop cancer prevention and control activities.

Zvara is the cancer program coordinator in the Chronic Disease Surveillance Unit, Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health; Anderson is supervisor of the Chronic Disease Surveillance Unit; Dr Remington is a medical epidemiologist in the Chronic Disease Surveillance Unit; and Dr Anderson is chief of the Section of Environmental and Chronic Disease Epidemiology. Part of this work was made possible by a grant from the National Cancer Institute (#RO1-CA-46883). Reprint requests to: Patrick Remington, MD, Wisconsin Division of Health, 1 W Wilson St, Madison, WI 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin.

Background

In 1988, Wisconsin was one of seven states initially selected to receive the grant, entitled "Data-Based Interventions for Cancer Control." The objective was to develop a cancer control plan and program based upon a careful review of state-specific cancer data. Following receipt of the NCI grant award, the Wisconsin Division of Health convened a planning coalition to analyze Wisconsin cancer data and to determine the priority cancers to be targeted for intervention with NCI funds.

The coalition looked at data from sources including the Wisconsin Cancer Reporting System, Health Status Survey, Hospital Discharge Survey, Ambulatory Medical Care Survey and death certificate information. Criteria for ranking of cancers for priority attention included size of the problem, severity of the problem and effectiveness and feasibility of intervention. Potential interventions were then examined for favorable cost/benefit ratio, acceptability and availability of resources to undertake the programs. The coalition's analysis and discussion resulted in the selection of breast cancer as the initial target for intervention under the NCI program.

Strategies

The table shows the objectives developed for breast cancer control. Program staff defined five intervention strategies to achieve these objectives:

Public information. Program staff contacted representatives of Wisconsin print and electronic media to acquaint them with available data and information resources. A series of press releases was begun, focused on such topics as trends in early detection of breast cancer, mammography guidelines and practices in Wisconsin, and mammography quality assurance. Television, radio and print media coverage of cancer information has subsequently occurred in both large and small communities in all areas of the state.

Professional education. The focus of professional education has been on

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publishing articles in professional journals about Wisconsin cancer trends and cancer control practices. In addition, program staff regularly make presentations to professional audiences through conferences and grand rounds. The program published and is currently distributing to physicians and other health professionals an information guide of breast cancer education and support resources for use with patients.[2]

Community based service programs. In 1989 and 1990, the Department collaborated with the American Cancer Society-Wisconsin Division to coordinate the Breast Cancer Detection Awareness Project, a month-long cooperative venture with local clinics, hospitals, and physicians in which reduced-cost mammograms are offered on a self-refer basis. Since the BCDA Project began in 1987, 33,556 Wisconsin women have been screened. Approximately 175 cancers were detected from 1987 through 1989.

The NCI grant has also enabled the Department to implement a program (also in cooperation with ACS) encouraging employers to offer breast cancer screening and education programs at the worksite. In April, 1990, a planning packet for worksite breast health programs was distributed to major employers throughout the state. Typical worksite programs include education activities, on or off-site mammography screening, as well as efforts to adapt company insurance policies to cover screening mammography. Since the initiative began, 60 worksites have planned or implemented breast health programs for their employees.

Finally, funds from the ongoing Governor's Cancer Initiative were used to support several community programs. In particular, $100,000 was provided to the Milwaukee Breast Cancer Awareness Task Force, to provide free mammograms to low-income women in Milwaukee.

Public policy and legislation. One goal of the NCI's public health initiative was to enhance state legislators' knowledge of cancer issues. Although state health departments are generally constrained from advocating for particular legislation, they are in a position to provide data and information to assist in development of laws, rules and policies. In Wisconsin, cancer program staff provided such technical assistance in the development and implementation of two laws enacted during the last legislative session: 1989 Wisconsin Act 129, which mandates coverage of mammography for women of certain ages under most health insurance policies; and a section of 1989 Wisconsin Act 336, the state budget, which creates the rural breast cancer screening mammography program. Through this program, approximately $422,000 is provided annually for mammography services through private providers to under-served women in 12 rural counties.

Another NCI goal was the development of state cancer plans. Cancer program staff participated in the development of Wisconsin's plan, which is now included in *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000.*[3] This document outlines strategies that public health agencies, private providers of health care services, and the business community can take to achieve improved health for Wisconsin citizens, including more effective prevention and control of cancer.

Quality assurance. The cancer control staff continues to work with the Radiation Protection Section of the Department to publicize results of annual mammography equipment quality assurance tests. These tests have shown that mammography equipment used in Wisconsin provides a radiation dose within accepted safety limits. Most mammography

Series coordinators: The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, are coordinating this series for the *Wisconsin Medical Journal*. For more information about the cancer program and its reports and publications, call Judith Zvara, coordinator, at 608-266-3500.

Objectives of the Wisconsin Breast Cancer Control Program.

- Increase public awareness and knowledge of the current breast cancer screening guidelines, including breast self-exam, physical exam and mammography, and of the importance of breast cancer screening.
- Increase the proportion of women in Wisconsin who follow the current breast cancer screening guidelines.
- Increase the proportion of women in Wisconsin who are diagnosed in earlier stages of breast cancer.
- Reduce financial barriers to obtaining regular mammograms.
- Increase the involvement of local public health departments in breast cancer control.
- Increase the proportion of women referred for mammograms who are from high risk populations.
- Increase the number of health professionals who are trained to and who perform breast cancer patient education, breast examination and referral for mammography.

facilities are producing high quality radiographs and film processor efficiency is good.[4]

Comment

The National Cancer Institute's publication of national objectives for the prevention and control of cancer recognized that in the case of breast, cervical, and smoking-related cancers, the knowledge and the technology exist to achieve marked reductions in morbidity and mortality. The NCI continues to view state public health agencies as key actors in reaching the national objectives, by applying cancer data to the development of state-specific goals and the resources and activities needed to achieve them. With the support of NCI, Wisconsin is defining its public health role in cancer control and refining its ability to apply data towards development of information and services that will prevent, detect early or effectively treat certain cancers.

Acknowledgements

The authors appreciate the assistance of Paula Lantz and Susan Latton in reviewing the material for this article, and the technical assistance provided by Leslie Boss, PhD, and Marianne Haenlein, PhD, of the NCI.

References

1. Greenwald, PG and Sondik, EJ, editors: *Cancer Control Objectives for the Nation: 1985-2000.* NCI Monograph No. 2, NIH Publication No. 86-2880, U.S. Department of Health and Human Services, 1986.
2. *Breast Cancer Detection, Treatment, Rehabilitation: Information and Resources for Your Patients.* POH #4475, Wisconsin Department of Health and Social Services, Division of Health, 1990.
3. *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000.* POH #4451, Wisconsin Department of Health and Social Services, Division of Health, 1990.
4. Bunge M, Zvara J, Remington PL: The Wisconsin Mammography Quality Assurance Program. *Wis Med J* 1990:89(9):527-528.❑

SMS helps develop cost containment proposals

Since June 1990, the SMS, Wisconsin Manufacturers and Commerce, Wisconsin Association of HMOs, Wisconsin Association of Life and Health Insurers, and Wisconsin Hospital Association, have been working toward developing a consensus package of health care cost containment initiatives. The coalition developed a 12-issue strategy designed to control health care costs.

The priority issues are:

- Restructuring health insurance plan parameters. Seeks support to implement co-pays, deductibles, lifestyle-related premiums and the evaluation of cost effective health care options into an employee health insurance plan.
- Health care for the uninsured. Key steps include developing a basic benefits plan for small employers not now offering insurance, and taking steps to assure that primary care is provided to all pregnant women and young children.
- Health insurance for small business. A number of reforms were identified to make health insurance more available and affordable to small groups.
- Medicare and Medicaid cost shifting. Support was provided for more equitable Medicaid reimbursement for physicians and hospitals.
- Mental Health and Alcoholism and Other Drug Abuse Services. Several proposals received support, including a state moratorium on new psychiatric and AODA inpatient hospital beds.
- The effective use and dissemination of health care data and information. Supports stronger use of the Office of Health Care Information in measuring quality and obtaining broader funding mechanisms.
- Health care capital technology and service expansion. Calls for development of a council on health care technology to identify projects necessitating public notice and involvement before legal or financial commitments are obtained.
- Medical liability costs. A number of proposals relating to medical liability reform were addressed.
- Impediments to consolidation and cooperation among providers. Cooperation between health care providers should be encouraged, and legal impediments evaluated and amended as appropriate.
- Practice parameters. Encouragement should be provided to develop practice parameters which "will assist physicians in providing the best quality and cost effective care possible."
- Access to rural health care. The coalition supports legislation to establish "rural medical centers" to

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provide a broader range of health care services.

- Health care cost containment discussion group. Supports the continuation of the coalition to meet to identify public policy and private sector initiatives aimed at controlling costs and improving the delivery of health care in Wisconsin.

"The development of this joint plan is noteworthy in that business and industry have begun to take notice of the increasing problem of inadequate payment for health services by the state and federal governments," said SMS Secretary-General Manager Thomas L. Adams, CAE. "Health care cost containment policy is best developed cooperatively, and it is good to have this new partnership committed to working toward containment of private health care costs."

The group intends to present its plans to state lawmakers.❑

For more information

A more detailed explanation of the 12 proposals created by the SMS, WMC, WHA and health insurers will appear as an insert in the May 29, 1991, *Medigram*. If you would like additional copies of that insert, please call the SMS Division of Communications at 1-800-362-9080 or 608-257-6781.

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

Preserving the past, building the future

Giving to the SMS Charitable, Educational and Scientific Foundation demonstrates your appreciation for medicine's past and your hope for medicine's future. The CESF preserves the past at the Ft Crawford Medical Museum in Prairie du Chien, and builds the future with educational loans for students pursuing careers in health care. Call to learn what more you can do: 1-800-362-9080 or 608-257-6781.

February 1991

* Bernstein, Steven A., Burlington
* Budzak, Kathryn S., Madison
* Desbiens, Norman A., Marshfield
* Dibbell, David G., Madison
* Elias, sharon L., Milwaukee
* Finch, David R., Appleton
* Gingrass, Ruedi P., Milwaukee
* Gottschalk, Paul G., Marshfield
* Gueldner, Terry L., Manitowoc
* Hetsko, Cyril M., Madison
* Hogan, John P., Milwaukee
* Kloehn, Ralph A., Wauwatosa
* Koob, Lynn D., Rice Lake
* Korkos, George J., Milwaukee
* Nordby, Eugene J., Madison
* Olson, Carl E., Mequon
* Ortell, Steven W., Milwaukee
* Paquette-Schulgit, C., Racine
* Rademacher, Ruth M., Milwaukee
* Schneider, George R., West Allis
* Steinke, Emil B., Ladysmith
* Wedro, Benjamin C., La Crosse
* Willson, D. Maclean, Milwaukeee
* Zarwell, David H., Milwaukee
* Ziegler, Judy P., Janesville

March 1991

* Alexander, A. Charles, Racine
* Bartl, George R., Waukesha
* Chesna, Edward J., Fond du Lac
* Diestelmeier, Michael R., Altoona
* Hansen, Thomas R., Janesville
* Holt, James J., Marshfield
* Karen, Robert, Milwaukee
* Keepman, Jay P., Stoughton
* Samadani, Ayaz M., Beaver dam
  Sanfelippo, Michael, Milwaukee
* Seelen, Michael C., Marshfield
* Sherkow, Larry H., West Bend
* Siegel, Lawrence K., Wauwatosa
* So, Elson L., Marshfield
* Stoerker, Ruth A., Madison
* Stram, Thomas W., Marshfield
* Suarez, Louis A., Appleton
* Todd, Paul C., Menomonee Falls
* Walz, John E., Stanley
* Weisenthal, Charles L., Milwaukee ❑

A new hand assumes the SMS helm

Cyril M. "Kim" Hetsko, MD, an internist and infectious disease specialist from Madison, assumed the presidency of the SMS at the annual meeting in April. He succeeds Roger L. von Heimburg, MD, of Green Bay.

In his presidential inauguration address, Dr Hetsko stressed the seriousness of the unevenness of health care in Wisconsin. He pledged to work toward the goal of providing quality health care at reasonable expense, and to a "new era of recommitment to individual contributions to the public good."

"Wisconsin physicians have a tradition of assuring that no person goes without health care because of financial or other concerns," said Dr Hetsko. "I challenge physicians to renew this commitment to providing medical care that combines the best of science and the best of compassion."

Dr Hetsko urged key players in health care–the physicians, the patients, the business community, state and federal governments, the pharmaceutical industry, the insurance companies, and the hospitals–to accept responsibility and do their part to assure that access to quality medicine is preserved for Wisconsin citizens. The full text of Dr Hetsko's remarks will appear in the July issue of the *Wisconsin Medical Journal.*

Born in Montclair, NJ, Dr Hetsko received his BA from Amherst College, in Amherst, Mass. He received his medical degree from the University of Rochester School of Medicine and Dentistry, in Rochester, NY. Dr Hetsko completed his internship and residency, and was chief resident, at the University of Wisconsin Hospitals in Madison.

Dr Hetsko served in the US Army from 1972 to 1975 as a research internist at the US Army Medical Research Institute of Infectious Diseases and the Walter Reed Army Medical Center.

During his tenure on the SMS Board of Directors (1979-1988), he served on the Executive Committee and as a member and chair of the Finance Committee. Dr Hetsko has served on the Task Force on the Resource-Based Relative Value Scale, and since 1987, Dr Hetsko has chaired the Task Force on AIDS. He has been an AMA alternate delegate since 1983 and has actively participated in the North Central Medical Conference. Dr Hetsko was elected vice speaker of the SMS House of Delegates, and served from 1988 to 1990, at which time he was elected president elect.

Active at the grassroots level, Dr Hetsko has been a leader with the Dane County Medical Society, and had served as chair of its former

Cyril M. "Kim" Hetsko, MD

Health Maintenance Plan Committee and the Committee on Prepaid Health Care Plans. He has given numerous presentations on HIV and AIDS, and health care within the Madison community.

A member of the Wisconsin Society of Internal Medicine, Dr Hetsko served as its president from 1987 to 1988. In addition, he was secretary-treasurer from 1985-1986, and a

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member of the governing council from 1982 to 1985. He was the recipient of the Addis Costello Award in 1990, presented to an outstanding Wisconsin internist. He has been a delegate to the American Society of Internal Medicine from 1986 to 1991, and currently serves on its Physician Payment Review Committee.

A clinical associate professor of medicine at the University of Wisconsin, he currently serves on the UW Search and Screen Committee for a new dean.

Dr Hetsko has been a member of the DeanCare HMO board of directors since 1983, a member of the board of directors of the Dean Foundation and Institute for Research from 1985 to 1987, medical director of laboratories at the Dean Medical Center since 1975, and chair of the Infection Control Committee since 1986.

A past chair of the Department of Medicine at St Mary's Hospital Medical Center, Dr Hetsko has also served on its Medical Staff Executive Committee and as a past member of its Institutional Review Board. Currently, he is a member of its Infection Control Committee and Pharmacy and Therapeutic Committee.

In 1988, Dr Hetsko was presented the Meritorious Service Award from the SMS for his 9 years of dedicated service to the SMS Board of Directors.

Dr Hetsko lives in Madison with his wife, Terry Hottenroth, director of Public Affairs for the SMS, and their two dogs. They both enjoy skiing and snorkeling.❑

SMS membership survey executive summary

Charles F. Rund and Carolyn R. Palmer, Charlton Research Company

In November 1990, Charlton Research Company (CRC) was retained by the State Medical Society of Wisconsin (SMS) to conduct quantitative research among its membership. The objectives of this research were to assess member attitudes and perceptions of SMS and to solicit opinions about the SMS priorities for the future.

More specifically, the objectives of the research were to:

- Assess the level of support for professional medical associations
- Develop physician word associations when thinking of the SMS
- Determine the SMS' effectiveness at various activities
- Assess the importance of various services the SMS offers
- Develop directions that the SMS should consider taking in the future
- Review the quality and courtesy of service offered by the SMS staff

The findings of the membership survey were presented to the SMS Board of Directors at its Strategic Decisions Seminar held January 17-18 in Madison. The seminar was facilitated by CRC and the results of the membership survey were used to aide in the discussion of current issues of importance to Wisconsin physicians.

Methodology

1990 survey

- 5990 surveys mailed November 9, 1990 by SMS
  - 5444 mailed to members
  - 546 mailed to residents
- Return date November 28, 1990
  - Allowed 10 days past due date for late returns
- 1149 mail surveys returned
  - 1109 from membership (20% return rate)
  - 40 from residents (7% return rate)
- Margin of error: ± 2.9%

1987 survey

- 5027 surveys mailed late August 1987 to regular SMS members
- Return date late October 1987
- 1703 mail surveys returned

Methods

To accomplish the above stated objectives, Charlton Research began working with the SMS in mid-October to design an appropriate mail survey instrument. Every physician had the chance to participate, as the survey was mailed by the SMS to all SMS members in early November, of which 5,444 were sent to members and 546 were sent to residents.

The completed surveys were returned to the SMS and then forwarded to CRC for data tabulation and analysis. A total of 1,149 surveys were returned, of which 1,109 were returned from members and 40 from residents. Mail surveys typically have approximately a 10% return rate, mainly because returning a survey is based on a self-selection process. SMS membership survey received a relatively high return rate, with a 20% return from members. Medical care and representation by the SMS are important issues to Wisconsin physicians, which may account for a high motivation to complete and return the survey. Also, organizations representing specific interests, such as SMS, often have an active membership.

Major findings

The SMS membership survey reveals some important insights into the attitudes and perceptions of the SMS and solicits a number of important insights as to the direction the SMS should consider during its strategic planning process:

- By a 2:1 ratio, the SMS is viewed positively by its membership, which is primarily associated with its lobbying efforts and representing and protecting physician interests.
- Members highly regard SMS efforts of communicating with the profession and consider the Society as being very effective at representing physician interests to the government, which are viewed at the Society's top two priorities.
- As a very small percentage of members contact the SMS more than once a year, the SMS should concentrate on initiating communications avenues that encourage member communication into the Society. The medical profession is rapidly changing and for the SMS to best represent member physician interests, communications must be two-way.
- Despite the wide array of activities where the SMS is perceived as effective, greater focus should be spent on conducting analysis of emerging social and economic issues, communicating with the public, being patient advocates and sponsoring scientific and educational activities.
- Sixty-three percent of SMS members consider themselves "inactive" members and county medical societies involve even fewer "active" members. As its membership is so vital to the continued success of the Society, the SMS should consider (in its strategic planning process) ways to encourage active participation on committees, commissions, and at county medical meetings.
- As the planning process proceeds, it is important to

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Comparison of survey respondents to regular State Medical Society membership

	% Survey Respondents	% SMS Membership*
Sex		
Male	87%	89%
Female	8%	11%
Age		
18-30	1%	2%
31-40	32%	37%
41-50	30%	30%
51-60	25%	21%
61-70	11%	10%
71 +	—	—
Specialty		
Internal Medicine	22%	20%
General/Family Practice	21%	20%
Surgery	18%	23%
Pediatrics	6%	6%
Obstetrics/Gynecology	5%	6%
Radiology	5%	6%
Anesthesiology	4%	5%
Psychiatry	3%	4%
Pathology	3%	2%
Emergency Medicine	3%	NA
Other	9%	8%

* = as of 1/7/91

Years of Membership

How many years have you been a member of the State Medical Society of Wisconsin?

2 years or less	15%
3-5 years	18%
6-10 years	18%
11-15 years	14%
16-20 years	12%
21-25 years	9%
26 years or more	14%

Continued from preceding page

remember that members want change. Currently, the SMS is viewed as changing primarily with the times. Members are looking for leadership, progress, and changes that will guide the profession well into the 1990s.

Analysis of findings

This section gives some detail to the general findings of the SMS membership survey research.

Demographic analysis

The results of the quantitative research are quite representative of the membership as a whole. Of the survey responses received, 87% were from men and 8% from women and according to January 1991 SMS data, the make-up of the SMS membership was 89% male, 11% female. Survey responses were primarily received from four age categories: 32% from those aged 31-40; 30% from those aged 41-50; 25% from those aged 51-60; and 11% from those aged 61-70. According to actual membership data, the 31-40 age category is slightly under-represented in the survey results, whereas the 51-60 age category is slightly over-represented.

The majority of respondents have been members of the SMS from 3 to 10 years, with 18% stating 3 to 5 years and another 18% stating 6 to 10 years. Almost half of those responding (49%) have belonged to the SMS for 11 years or more, with representation from those who have belonged from 11 to 15 years (14%), 16 to 20 years (12%), 21 to 25 years (9%) and 26 years or more (14%). Fifteen percent of the respondents were fairly new members who had belonged to SMS for 2 years or less.

Physicians responding primarily practiced in one of three specialties; surgery (21%), general or family practice and internal medicine (19%). Other specialty areas represented were obstetrics/gynecology (7%), radiology (4%), pediatrics (6%), anesthesiology (5%), psychiatry (4%) and pathology (3%). This representation corresponds very closely with actual membership

State Medical Society of Wisconsin Top of Mind

When you hear the words "State Medical Society of Wisconsin" or "SMS" what is the first thing that comes to mind?

Positive mentions (net)		**36%**
Lobby/PAC	12%	
Represents/protects physicians interests	10%	
Like it/general positive	3%	
Malpractice insurance/legislation	3%	
Physician/patient advocate	3%	
Informative	2%	
Benefits insurance	2%	
PartnerCare	*	
Neutral mentions (net)		**21%**
Physicians organization	7%	
Medigran/Wisconsin Medical Journal	4%	
Location	4%	
Dues/general	4%	
Meeting/committees	1%	
Local extension of AMA	*	
Negative mentions (net)		**18%**
Bureaucracy/not doing a good job	6%	
Don't like SMS/general negative	4%	
Lobby/PAC/negative	3%	
High cost of dues	2%	
Meetings/publications/negative	1%	
Not progressive	1%	
Other		**3%**
Don't know/no answer		**23%**

Reasons for membership

Why are you a member of State Medical Society of Wisconsin?

	First Mentions	Total Mentions
Support profession/physicians	13%	15%
Required/paid by my clinic employer	9%	10%
Have political voice/support lobbying	8%	11%
Represents physician/patient interest	7%	9%
Periodicals/be informed up to date	7%	9%
Feel obligation/duty/habit	6%	6%
Insurance/general	5%	7%
Can accomplish more as united group	5%	6%
Influence/be involved in policy making change	5%	6%
Malpractice insurance/required by malpractice insurance	4%	5%
Effective/doing a good job	2%	3%
Opportunity to meet/communicate with colleagues	2%	2%
Organized medicine/general positive	2%	2%
Benefits/support services/ education PR	1%	3%
Other	1%	3%
Don't know/no answer	21%	21%

data.

The majority of the SMS members practice medicine in a "group practice" with more than 6 in 10 respondents (61%) stating as such. Compared to 1987 data, membership has shifted away from physicians practicing as solo practitioners toward practicing in a group. This shift is worth highlighting as SMS begins to plan strategically for the future.

Reasons for membership

By more than a 3:1 margin, respondents perceive the SMS positively. When asked what first comes to mind when hearing the words "State Medical Society of Wisconsin" or "SMS", 57% responded with either a positive (36%) or neutral (21%) comment, which is higher than in other states CRC has reviewed. Positively, the SMS is primarily associated with its lobbying and PAC efforts (12%), and representing and protecting physicians interests (10%). Neutral mentions were generally descriptive of services, such as being a physician's organization (7%), the *Medigram* or *Wisconsin Medical Journal* (4%), the location of SMS (4%), general comments about dues (4%), and mentions of meetings or committees (4%).

Negative comments were mentioned by 18% of those surveyed and primarily focused on perceptions that the SMS is a bureaucracy and they are generally not doing a good job (6%) to general negative comments (4%). Also important to note is that almost one quarter (23%) of respondents did not associate anything when thinking of the SMS, even though they are members.

The SMS has a diffused image. When respondents were asked why they are a member of the SMS, 14 major reasons were stated. It is very difficult for an organization to communicate 14 different things to its membership and time must be spent on figuring out just what the SMS wants to communicate most. One-fifth of respondents (21%) did not state why they were a member.

Stated reasons for belonging to the SMS can be described in a philosophical, duty, product or advocacy sense. Philosophically, 15% mentioned they belong because it is one way to support the profession and other physicians. Describing the SMS membership as a duty entails a required membership, or one that is paid by an employer (10%), or membership is more of an obligation or habit (6%). Some physicians are members because of products offered by SMS, such as periodicals and information dispersal (9%), general insurance mentions (7%), malpractice insurance (5%), and benefits, and support services, and continuing education (3%). And lastly, some members belong for advocacy reasons such as lobbying support and having a political voice (11%), SMS represents physician and patient interests (9%), more can be accomplished as a united group (6%), and being involved in policy to encourage change (6%).

Respondents were also asked how membership in the SMS has been most useful to them personally. Although almost one third did not comment, and 9% stated that membership is not personally useful, others stated the SMS has been personally useful in the advocacy sense by representing physicians in the

Continued on next page

Practice

Please check the one category that best describes your practice:

	1990	1987
Solo practitioner	21%	24%
Group practice	61%	58%
Hospital based	7%	7%
Hospital employee	1%	1%
HMO employee	1%	1%
Academic	6%	5%
Administration	2%	2%
Other	*	—
No answer	2%	3%

SMS membership: personal usefulness

Over the last few years, in what ways has membership in SMS been most useful to you?

	First Mention	Total Mentions
Representing physicians in the legislature	14%	16%
Insurance/general	10%	12%
Information about legislature/ policies/doctor issues	9%	11%
Not useful	9%	9%
Information about policies/ issues affecting physicians	6%	9%
Medigram/newsletter/journal	6%	8%
Malpractice insurance	4%	5%
Chance to meet colleagues/ committees	4%	5%
Information about Medicare	2%	2%
Educational programs/support services	1%	3%
Social/economic issues	1%	3%
Office/staff management	1%	2%
Legal advice	1%	2%
CME/continuing medical education accreditation	1%	1%
Other	1%	2%
Don't know/no answer	30%	30%

Continued from preceding page

legislature (16%), and in the product sense through offering insurance (12%), distributing information about legislative and policy issues associated with the medical profession (11%), providing the *Medigram*, newsletters and *WMJ* (8%), and offering malpractice insurance (5%). Some respondents (5%) also mentioned that membership offers the chance to meet colleagues and participate on committees.

An interesting finding is that almost one third of the respondents (32%) state that they never contact the SMS, 36% only contact the Society a few times a year, and 19% contact the Society once a year. Communication is apparently considered a one-way street. Thinking strategically, the SMS should concentrate on initiating communications avenues that encourage member communication with the SMS, and vice versa. The medical profession is changing so rapidly that, for the SMS to best represent its member physician interests, avenues for communication into the Society must be encouraged. Those respondents who do contact the SMS state the quality and courtesy of service is extremely high, emphasizing that they are pleased with the staff service they received when contact is made.

SMS effectiveness and importance of activities

Respondents were asked a series of statements concerning activities the SMS is involved in and asked whether the SMS was effective at accomplishing those activities. By a 6:1 margin, respondents felt the SMS was extremely effective at communicating with the profession, and by a 5:1 margin the SMS has been effective at representing physician interests to the government. These are very high achievement marks and SMS efforts are widely recognized by member physicians. Respondents also felt that the SMS was effective at political candidate support through WISPAC, and offering member benefit programs such as insurance and leasing, both activities supported by a 2:1 margin.

Respondents held a more neutral opinion about the SMS effectiveness in three areas: 1) conducting analysis of emerging social and economic issues; 2) sponsoring scientific and education activities; and 3) offering consulting services to the membership. One activity mentioned in which the SMS is not effective is in being patient advocates. Although almost half of respondents held a neutral opinion, 19% stated that the SMS is effective, and 31% that they were not effective at being patient advocates. Perceptions of respondents indicate that the SMS should place greater emphasis on this activity in the future.

When asked to prioritize all of the above stated SMS activities, 24% stated that the SMS' first priority should be representation to the government, followed by 12% stating priority focus should fall on communications with the profession, and 9% stating conducting analysis of emerging social and economic issues. The SMS is viewed as quite effective at achieving what respondents view as the Society's first priority, representation of the profession to the government, as well as being effective at achieving its stated second priority, communication with the profession. Following these

Continued on page 246

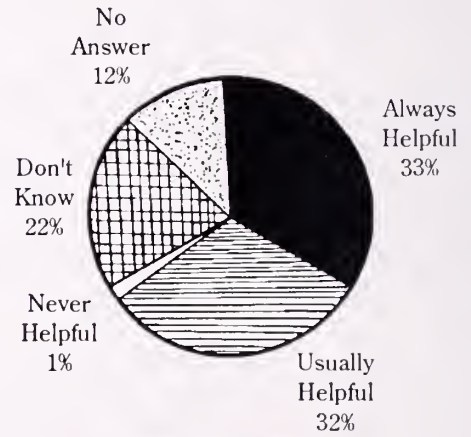
Frequency of Contact

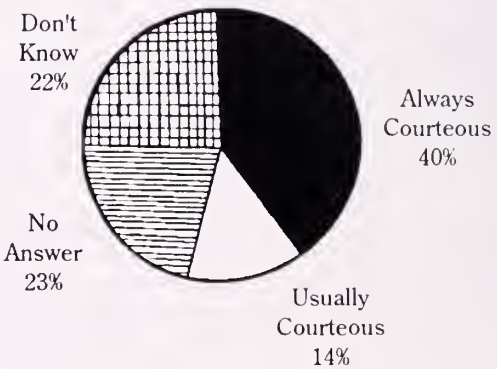
How frequently do you contact SMS?

Once a week	1%
Once a month	6%
A few times a year	3%
Once a year	19%
A few times a year	36%
Never	32%
No answer	2%

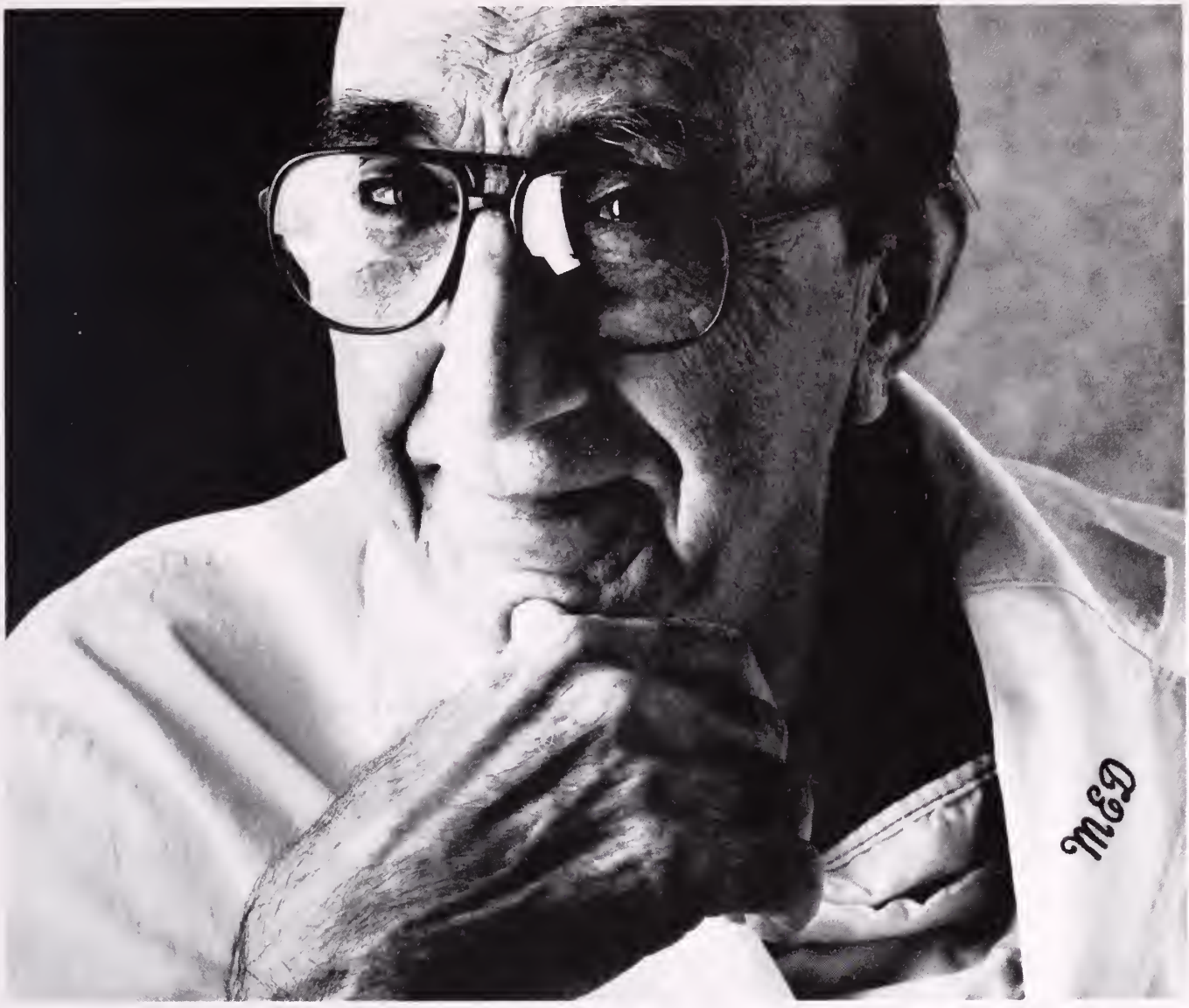
Quality and courtesy of service

How would you rate the quality and courtesy of service you have received from the SMS staff when you contacted them?





Join Dr. DeBakey.



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"This is a time when we need a unifying force in the medical profession very badly.

"As a member of the AMA, I'm part of an organization that's involved in my life work and through it, I feel I have a relationship with other doctors. Together, we're all working toward the improvement of the medical profession and our relationship with our patients. And that's what the American Medical Association is all about."

Join Dr. Michael E. DeBakey, Chancellor and Chairman, Department of Surgery, Baylor College of Medicine, in the AMA. Call this toll-free number now.

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American Medical Association

Continued from page 244

two activities, respondents felt more priority focus should be placed on areas where the SMS is perceived as less effective: conducting analysis of emerging social and economic issues, communicating with the public, being patient advocates, and sponsoring scientific and educational activities. Two areas where the SMS is viewed as effective but also viewed as lesser priority areas are political candidate support through WISPAC and offering member benefit programs.

A more extensive list of activities and services was also surveyed, and the respondents indicated that

Continued on next page

SMS priority activities

Please review the activities mentioned in questions 11-19 and circle the one activity that you feel should be SMS's first priority.

	Total
Representation to the government	24%
Communication with the profession	12%
Analysis of emerging social/economic issues	9%
Communication with the public	7%
Being patient advocates	5%
Scientific/educational activities	2%
Consulting services to the membership	1%
Member/benefit programs	1%
Political candidate support (WISPAC)	*
No Answer	37%

SMS membership: more effective

In your opinion, where could SMS be more effective? What new or additional activities, services or benefits would you like to see SMS provide?

	First Mention	Total Mentions
Educating the public about health care	8%	10%
Public relations/improve public image	8%	9%
Government involvement/ legislative process	7%	8%
Represent/unite all physicians	6%	8%
Do a better job/be more progressive	3%	4%
None/doing a good job	3%	3%
Physician support services	3%	3%
Malpractice issues	2%	3%
Third party payers	2%	2%
More information/updates on new policies	1%	2%
Medicare/Medicaid issues	1%	1%
Issues of the uninsured/ national H.C.	1%	1%
Insurance programs	1%	1%
Physician recruitment	1%	1%
HMO's negative	1%	1%
Issues concerning the high cost of medicine	1%	1%
Other	1%	1%
No Answer	51%	51%

State Medical Society effectiveness ranked by effectiveness

The following is a list of activities. How effective do you feel the SMS is for each activity? On a scale of one to five where "1" means very effective and "5" means not at all effective, please circle the number corresponding to how effective you feel SMS is at each of the following activities.

	Net Effective	Neutral	Net Not Effective
Communication with the profession	59%	28%	10%
Representation to the government	52%	32%	13%
Political candidate support (WISPAC)	41%	36%	17%
Member benefit programs (insurance, leasing, etc.)	41%	37%	16%
Analysis of emerging social and economic issues	30%	41%	25%
Scientific and education activities	27%	46%	24%
Consulting services to the membership (medical/legal, contracting, etc.)	25%	43%	25%
Being patient advocates	19%	45%	31%
Communicate with the public	13%	39%	45%

Continued from preceding page
the majority of the SMS services offered were rated according to the priority areas discussed above. A total of 23 services were assessed, of which 14 were previously assessed in the 1987 membership study. Respondents emphasized much continuity between surveys, including one service that was viewed as unimportant, such as operating the Fort Crawford Medical Museum, (29% feel it is an important service whereas 69% view it as unimportant). As the list of 23 services is a more detailed reflection on discussion of the above stated priorities, each will not be discussed.

Member assessments of SMS and organized medicine

Over the past few years the SMS and other medical organizations have seen a shift away from active participation of their members. Survey results indicate that more than 6 of 10 (63%) SMS members consider themselves "inactive" and 32% consider themselves "active," whereas the 1987 survey results showed a higher percentage of active members. By a 2:1 margin, the SMS members state they are not very involved with their representative organization. By comparison, the AMA shows even less active involvement than the SMS, and it seems that physicians are becoming more

Importance of SMS activities

How important or unimportant to you are the following services of the State Medical Society?

	Very Important	Somewhat Important	Not too Important	Not at all Important
(1) Representing medicine's views to state legislators	82	14	2	1
(2) Representing medicine's views to Congress	76	17	3	1
(3) Representing medicine's views to regulatory agencies	74	20	3	1
(4) Communicating medicine's concerns to the public	73	22	3	*
Developing new policy on issues affecting the practice of medicine	51	40	6	1
Improving the image of the profession within the profession	45	34	15	4
Assisting physicians in becoming effective players in the political process	44	41	11	3
Analyzing information on emerging socio-economic issues for use in policy development	43	44	9	1
(6) Helping physicians deal with third party payors	42	42	11	4
(7) Operating an impaired physician program	39	44	13	2
Publicizing SMS efforts to improve the public's access to care (Partner Care, placement service)	39	43	14	3
Advocating for patients	36	42	17	3
(5) Supporting political candidates through WISPAC	30	43	16	8
(8) Publications (*Medigram, Wisconsin Medical Journal)*	24	49	21	5
(10) Providing insurance programs and service plans	22	31	29	15
Publicizing the accomplishments of Wisconsin physicians (clinical/scientific and community oriented)	21	45	26	6
Offering programs to assist those interested in pursuing careers in medicine	19	49	25	4
(11) Providing continuing education for physicians	18	35	33	12
(9) Patient information/brochures	13	41	35	9
Providing scientific programs at SMS annual meeting	13	39	35	11
(13) Offering practice management services and financial planning seminars	12	46	33	8
Sponsoring a Fall Medical Issues Conference	9	41	36	10
(14) Operating a museum of medical progress (Fort Crawford Medical Museum)	3	26	47	22

( ) = 1987 Survey Results

actively involved in specialty societies, especially as leaders and members of a hospital medical staffs. This reflects the fact that more than 60% of the SMS membership is represented by physicians in group practice. County medical societies also rated low on the involvement level. This is a direct reflection on the SMS, as the county medical societies are components of the SMS and the Society's potential for support or effectiveness arising at the country level diminishes as participation of members at the county level diminishes.

An additional measure of support for the SMS and other medical organizations was conducted by asking respondents to evaluate the AMA, their national specialty society, their county medical society and the SMS with respect to perceptions of their current posture and what posture they would prefer each association to take. An assessment of the four organizations identifies the extent to which individual physicians believe the organizations should be more or less progressive at representing physician needs. Responses indicate that even though members show strong support for the SMS in general, the Society needs to be more progressive and active concerning health issues and changes that are constantly occurring in health care in Wisconsin. The AMA and the county medical societies clearly have the furthest distance to travel according to current perceptions, whereas the national specialty societies are perceived as affecting the most change. The SMS rates in between.

The AMA is considered a passive rather than active organization, as 19% perceive its current posture as "maintaining the status quo" and 37% say it "changes only when necessary," whereas more than 80% of the respondents state the preferred posture for the AMA would be to "take a progressive attitude toward change" or be "at the forefront of change."

National specialty societies are viewed as being the most active of the four organizations, but even so 71% perceive the current status as either "taking a progressive attitude toward change" (37%), or being "at the forefront of change" (19%), whereas 84% prefer the association to be more progressive (41%) or be at

Continued on next page

Assessment of professional association current and preferred posture

	1987		1990	
	Current	Preferred	Current	Preferred
American Medical Association				
Maintain status quo	19%	2%	19%	1%
Change only when necessary	35%	3%	37%	3%
Change with the times	27%	14%	24%	11%
Take a progressive attitude toward change	16%	44%	15%	44%
At the forefront of change	4%	37%	2%	39%
Your national specialty society				
Maintain status quo	6%	2%	4%	1%
Change only when necessary	11%	3%	9%	2%
Change with the times	26%	10%	25%	8%
Take a progressive attitude toward change	41%	41%	37%	41%
At the forefront of change	16%	43%	19%	43%
County medical society				
Maintain status quo	32%	4%	28%	3%
Change only when necessary	26%	6%	26%	4%
Change with the times	27%	24%	30%	25%
Take a progressive attitude toward change	13%	42%	9%	41%
At the forefront of change	2%	24%	1%	24%
State Medical Society				
Maintain status quo	10%	2%	8%	*
Change only when necessary	18%	3%	23%	2%
Change with the times	36%	14%	39%	15%
Take a progressive attitude toward change	31%	50%	24%	49%
At the forefront of change	6%	32%	3%	31%

Medical organization involvement

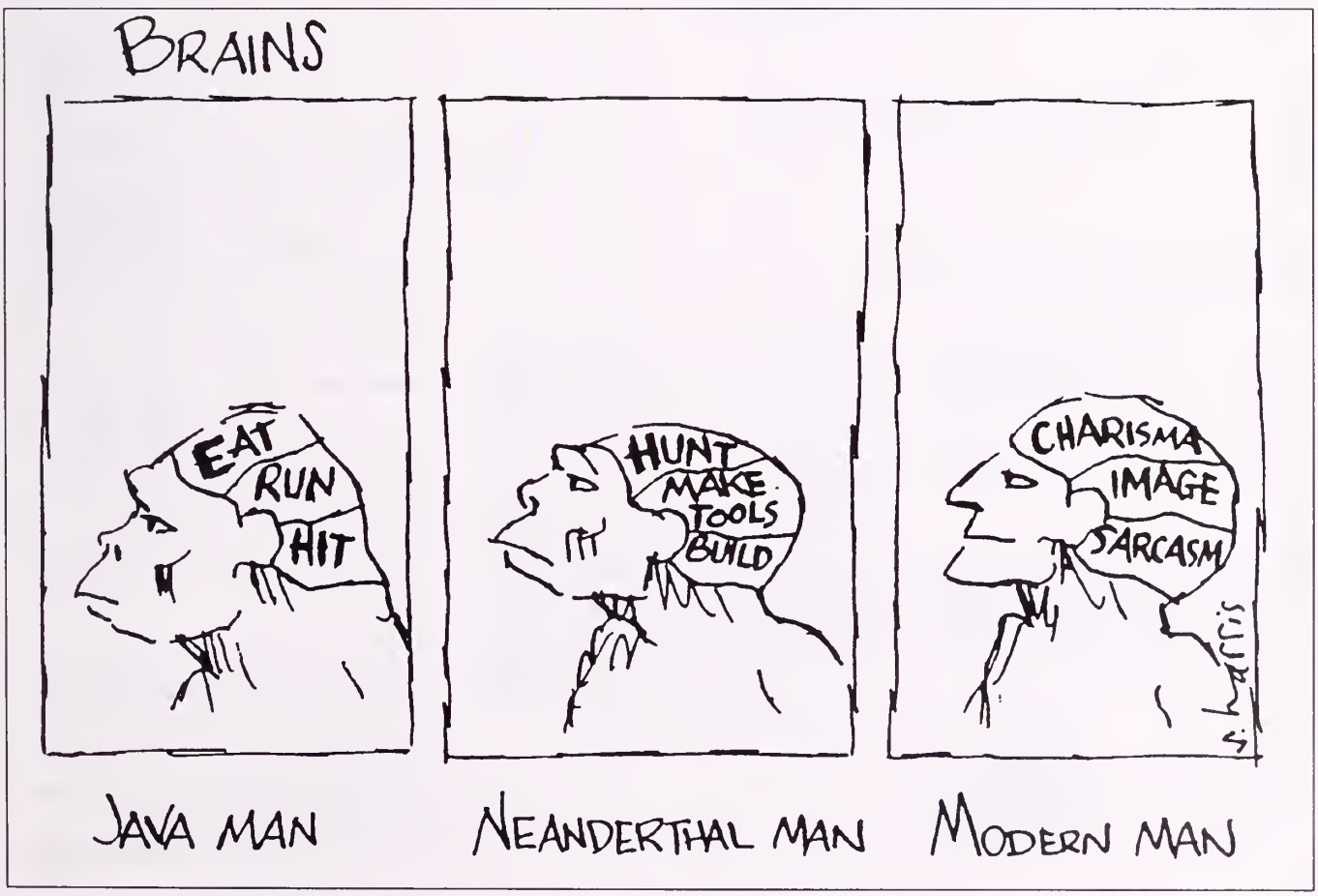
How would you describe your own level of involvement in each of the following medical organizations? Would you say you are an active leader, an active member, an inactive member or not a member?

	Active Leader		Active Member		Inactive Member		Not a Member	
	1990	1987	1990	1987	1990	1987	1990	1987
State Medical Society of Wisconsin	3%	4%	32%	39%	63%	56%	*	*
County Medical Society	7%	8%	36%	41%	54%	51%	*	*
American Medical Association	1%	1%	15%	21%	46%	53%	35%	24%
Specialty society (ies)	12%	11%	52%	53%	28%	31%	5%	6%
Hospital Medical Staff	33%	33%	54%	58%	10%	8%	1%	1%

Continued from preceding page
the forefront of change (43%).

County medical societies are perceived as the most passive of the four organizations, whereas respondents felt a strong preference for the change. Essentially the county medical societies are viewed as maintaining their current programs rather than being progressive, and this is a direct reflection on the SMS, as the SMS helps direct activities at the county level as an umbrella organization.

By a 1:3 margin, the SMS current versus preferred status is viewed as progressively changing, as 3% view the SMS as currently being at the forefront of change and 31% prefer the active change status. The SMS is primarily viewed as "changing with the times" whereas respondents would prefer the SMS to take a more progressive attitude toward change.❑



Physician briefs

The * indicates SMS members.

Peter Holzhauer, MD,* of Brookfield, has been elected to serve a second 2-year term as director of the Wisconsin Chapter of the American College of Emergency Physicians, Inc. Dr Holzhauer is director of the department of emergency medicine at Trinity Memorial Hospital in Cudahy, and serves as chair of the Milwaukee County Medical Society's Emergency Medical Services Committee.

Ghulam Mohammad, MD,* of Sheboygan, is the recipient of the Pediatrics Review and Education Program Fellowship Award of the American Academy of Pediatrics. A pediatrician, Dr Mohammad has been active for the past 6 years in the PREP continuing medical education program and is a fellow of the academy.

Steven F. Hansen, MD, of Amery, will join the Family Medical Clinic-Amery, in October. An internist, Dr Hansen received his medical degree from the University of Minnesota Medical School.

Everett R. Lindsey, MD,* of Mineral Point, recently joined the Southwest Health Center's obstetrician and gynecological staff in Platteville. An obstetrician and gynecologist, Dr Lindsey will see patients every other Friday.

Randall S. Kuhlmann, MD, of Wauwatosa, has been appointed assistant professor of obstetrics and gynecology, and anatomy and cellular biology at the Medical College of Wisconsin. An obstetrician and gynecologist, Dr Kuhlmann specializes in high-risk pregnancies.

Wayne McFadden, MD,* has been appointed chief of staff at Trinity Memorial Hospital in Cudahy. A family practitioner, Dr McFadden has served as a member of Trinity Memorial Hospital's medical staff since 1961.

Leonard Weistrop, MD, of Milwaukee, has been elected president of the Milwaukee Academy of Medicine. An internist, Dr Weistrop practices with Columbia Internal Medicine Associates at Columbia Hospital. He is also an assistant clinical professor at the Medical College of Wisconsin.

Andrea Gavin, MD,* and **George Poullette, MD,*** of La Crosse, will join the Sheboygan Clinic when it opens its expanded satellite office in Plymouth this summer. Family practitioners, Drs Gavin and Poullette will live in Plymouth.

Lewis Barness, MD, of Madison, will receive two awards for his contributions and leadership in pediatric medicine over the past 4 decades. Dr Barness will receive the Jacobi Medal, the highest award given by the American Academy of Pediatrics, for notable contributions to pediatrics on a national level, and for accomplishments in teaching, patient care and clinical research. Dr Barness will also receive the St Geme Award from the American Pediatric Society. The award acknowledges those who are role models "creating the future" of pediatrics through research or clinical practice. Dr Barness is known internationally for his work on inborn errors of metabolism and on infant nutrition.

Joan Wake, MD,* of Sturgeon Bay, has been appointed medical director of Door County Counseling Services, Inc. A graduate of the University of Michigan Medical School, Dr Wake is currently on the staff of the Door County Memorial Hospital and main-

County society news

Brown. At the March meeting of the county society, John Stevenson, MD; Frederick Hamly, MD; Robert Griesser, MD; Brian Dodds, MD, and Roland Christian, MD, were accepted to membership.

Dane. Jack O. Bradt, MD; Randall K. Cullen, MD; Catherine C. Welling, MD, and Patrick S. Ramsey, MD, were accepted to membership at the March meeting of the society.

Marinette-Florence. At the February meeting of the county society, Linda Werner, MD, was elected to membership.

Vernon. Twenty-one members and guests were present at the March meeting of the county society. Guest speaker, Ben Logan of Gays Mills, spoke on local/regional medical history. Jack Lockhart, MD, SMS director from the 3rd district, spoke on the upcoming annual meeting resolutions and issues. Congratulations were offered to Phillips T. Bland, MD, of Westby, on receipt of the University of Wisconsin's Distinguished Medical Alumnus Award. ❑

tains a medical practice at Door County Medical Center.

John Garman, MD,* of Waterloo, was recently selected "Provider of the Year" at the Dodge County Emergency Care Association annual banquet. The award recipient is nominated by association members and selected by a representative panel.

Arnold A. Asp, MD, of Stoddard, has been elected to Fellowship in the American College of Physicians. An internist and endocrinologist, Dr Asp is the service chief of endocrinology at Dwight David Eisenhower Army Medical Center at Fort Gordon, Ga, and an assistant clinical professor, Department of Medicine, Medical College of Georgia.

John Lehman, DO, of Highland, has been named to the Memorial Hospital of Iowa County board of directors. Dr Lehman has been practicing at the Highland Medical Center for the past 12 years.

George Lind, MD,* of Beloit, was appointed medical director of Meadow Park Nursing Home. Dr Lind has been affiliated with the Clinton Clinic, an outreach center of the Beloit Clinic, since 1985. An internist, Dr Lind will supervise overall medical care within the facility.

Thomas C. Boyd, MD,* of Portage, recently joined Divine Savior Hospital. A graduate of the University of Illinois, Dr Boyd completed his residency at the University of Iowa. Dr Boyd is a general practitioner who also practices obstetrics and minor surgery.

Phillips Bland, MD,* of Westby, was honored in La Crosse by the Wisconsin Medical Alumni Association for his service to medicine and the community. A Westby city health officer, and team physician and medical advisor to the Westby school system, Dr Bland operates the Westby Clinic and sees patients at Vernon Memorial Hospital in Viroqua.❑

FIFTH ANNUAL

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Sessions run 9:00 a.m. 12:15 p.m. daily
CME and CEU credits available

July 22-26, 1991

Session I	Jay D. Haley, M.A.	Directive Therapy
Session II	Peter E. Sifneos, M.D.	Short Term Dynamic Psychotherapy

July 29-August 2, 1991

Session III	Donald Meichenbaum, Ph.D.	Cognitive Therapy
Session IV	MCW Department of Neurology	Neurology for Non-Neurologists

August 5-9, 1991

Session V	John H. Greist, M.D.	Anxiety Disorders and Their Treatment
Session VI	Robyn S. Shapiro, J.D. Charles L. Junkerman, M.D.	Medical Ethics in Clinical Practice

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News highlights

Dr Rover
More hospitals are working with four-legged therapists, according to *Medical World News*, and finding positive results for patients and staff members. Studies have demonstrated a link between involving animals, such as dogs, in hospital patient therapy and reduced patient requests for pain medication, shorter recovery times, and lower heart rates. In general, the animals give patients a focus other than their own ills. In particular, patients who are struggling with self-acceptance, such as amputees and stroke victims, find the unbiased affection of the animals helpful.

Dr Rover Part II
Physicians Financial News reports that owning a pet, particularly a dog, may reduce the demand for physicians' services among the elderly. A 1-year study of nearly 1,000 Medicare patients in a Los Angeles HMO showed that patients who owned pets visited their physicians less frequently than those without pets.

Arsenio or Johnny?
In a survey of 1,000 American adults, 33% said they watch television when they are having trouble getting to sleep. Thirty percent read, 29% do nothing, 13% exercise daily, 13% meditate, and 9% take sleep-inducing medications.

Money up in smoke
If the average price of a pack of cigarettes climbs from $1.75 to $2–which could happen if currently proposed legislation were to pass into law–a 2-pack-a-day smoker would spend $1,460 a year on cigarettes alone. In 20 years, that smoker would shell out $29,200; in 30 years, $43,800. That's an expensive habit, even before any possible related health care costs are incurred. ❑

Obituaries

Edward G. Stack Jr, MD, 75, of Superior, died Dec 15, 1990, in Superior. Dr Stack was born March 7, 1915, in Hayfield, Minn, and graduated from the Marquette University School of Medicine. His internship was completed at Misericordia Hospital in Milwaukee. Dr Stack was city health commissioner for many years and Douglas County coroner for more than 20 years. He served in the US Army for 2 years, in the US Public Health Service for2 years, US Army Reserves for 7 years, and the Wisconsin National Guard for 8 years. He was a member of the Douglas County Medical Society, the SMS, and the AMA. Surviving are his widow, Joanne; two daughters, JoAnn Golden, of Coon Rapids, Minn, and Claudia Kremer, of Minneapolis; and two sons, Edward, of Delafield, and John P., of Lake Nebagamon, Wis.

Royce Chiang-Tsun Lin, MD, of Green Bay, died Feb 8, 1991, in Green Bay. Dr Lin was born May 27, 1939, in Taiwan, and graduated from the National Taiwan University Medical School. He completed his internship at Louis A. Weiss Memorial Hospital, Chicago, and served a residency at William Beaumont Hospital, Royal Oak, Mich. A fellowship in nephrology was completed at George Washington University Hospital in Chicago, before coming to Green Bay in 1976. He opened the Green Bay Kidney Dialysis Center and the Manitowoc

Continued on next page

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑

Kidney Dialysis Center. He was a member of the National Kidney Foundation, the American Society of Nephrology, and the International Society of Nephrology. He also was a member of the Brown County Medical Society, the SMS, and the AMA. Surviving are his widow, Der Hua; four sons, Edward, Rudolph, Evan, and Wayne.

Gerald W. Poindexter, MD, 66, a former Milwaukee physician, died Feb 15, 1991, in Las Vegas. Dr Poindexter was born Aug 19, 1925, in Detroit, and graduated from Meharry Medical College in 1952. His internship was completed at Syracuse Medical Center, in New York, and his residency was served at the Veterans Administration in Wood. He served in the US Army from Oct 1943 to April 1946. He was a member of the Medical Society of Milwaukee County, the SMS and the AMA. Surviving is his widow, Delores. ❑

Sizing Up Employee Benefits

The AMA recommends a minimum health care benefits package that responds to many needs, particularly small business.

Consider the advantages of a no-frills, minimum benefits package.

For small business employees, who make up a large percentage of America's 33 million uninsured, it can mean the difference between receiving basic health care insurance coverage and none at all.

For small business employers, it can mean the ability to provide employee health care insurance — without being forced out of business by excessive costs.

The Health Access America proposal calls for a federal law requiring all employers to provide health insurance for their employees. To help businesses fulfill this obligation, the AMA recently defined a minimum level of coverage that offers substantial benefits at reduced premiums.

The AMA Minimum Benefits Package helps small businesses afford employee health care coverage — even if those benefits don't include all the bells and whistles.

Big businesses, spurred by labor, have traditionally used generous health care packages to attract the best workers — making the most of tax incentives and a large employee base that makes a large corporation attractive to insurance companies.

As a group, small businesses frequently pay more per employee. The big culprits in higher costs are state-mandated benefits. Studies indicate that benefit mandates add up to 20% to the cost of health insurance.

So, another aspect of Health Access America is a recommendation to eliminate mandates while still another would create state risk pools.

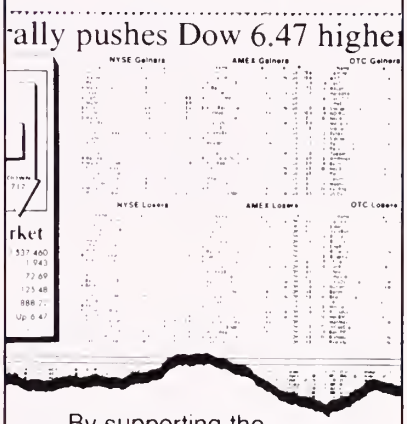
The Minimum Benefits Package, in combination with AMA-backed tax incentives and credits for small employers, is a major initiative to extend access to care to the millions of working uninsured.

Benefits Hightlights
- Pre- and post-natal care
- Up to 20 office visits per year
- Surgical treatment of illness/injury
- Emergency treatment
- 45 hospital inpatient days
- Dialysis
- Selected home health services

Basic deductible:
$350 individual
$750 family

A message from The American Medical Association for the Health Access America Proposal

Avoid capital gains tax. Support the American Heart Association.



By supporting the American Heart Association you may:
- avoid capital gains tax on appreciated securities or other property
- reduce current and future income taxes
- provide a lifetime income for yourself or beneficiaries
- avoid probate and publicity
- maximize estate tax savings

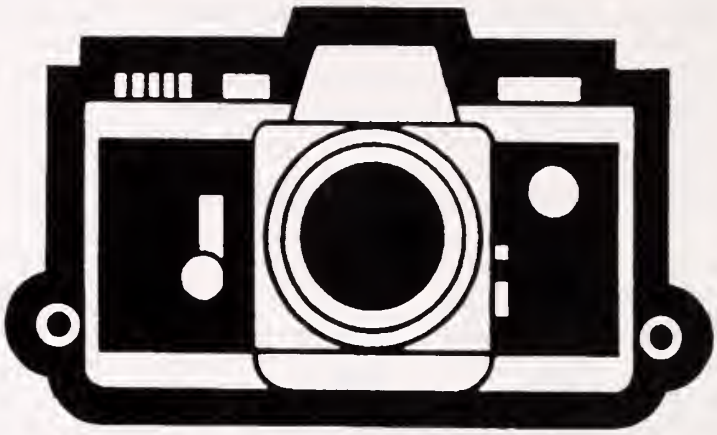
It may pay you to inquire about the American Heart Association's Planned Giving Program by contacting your local American Heart Association.

Sometimes, it can be better to give than to receive.

American Heart Association

This space provided as a public service

WMJ physician photo contest



Awards: Publication on the cover of the *Wisconsin Medical Journal* and a commemorative plaque, presented at the SMS annual meeting.

Eligibility: The competition is open to members of the State Medical Society of Wisconsin and its Auxiliary only.

Guidelines: A total of three entries in any combination of the following categories may be submitted.

- A doctor's life
- The science of medicine
- The art of healing
- Wisconsin wildlife
- Wisconsin places
- Wisconsin people

Entry in the contest constitutes agreement to allow the entered photographs to be published in or on the cover of the *Wisconsin Medical Journal.* Vertical photos are preferred, but horizontal photos are accepted. Entrants retain all other rights to their photographs.

Entries must be original prints or slides in color or black and white. Prints may be mounted, but not framed, and mount size should not exceed 11x14. Negatives must be available for all prints.

The back of each photograph must bear the photographer's name, address and phone number, and the title—if any—of the photo. Enclose, preferably on a separate sheet, a brief description of where, when and how the photo was taken. If possible, note the make and model of camera and lens used for each photo, film used, exposure settings, and any special equipment. Previously published material may be entered; however, please include the information on when and where the photo has appeared.

The *WMJ* cannot be responsible for entries—so do not send your only copy.

Deadline: All entries must be postmarked no later than February 14, 1992. Send entries to: Photo Contest, *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

Clinical instructor - flight physician. University of Wisconsin Hospital and Clinics, Madison, is recruiting for physicians (full or part-time) to participate as members of the medical staff of UW Med Flight, the helicopter critical care service. Responsibilities include providing critical care for patients transported by helicopter and providing occasional back-up coverage to patients in the emergency department. MD; completion of residency in surgery, internal medicine, pediatrics, family practice or emergency medicine is required. Certifications in advanced cardiac life support and advanced trauma life support are required. Previous experience in EMS systems and pre-hospital emergency medical care is desirable. Send resume to: H. Michael Bowman, MD, Chief, Section of Emergency Medicine, 600 Highland Ave, C5/325, Madison, WI 53792. Equal Opportunity Employer. 5/91

Urgent care. Marshfield Clinic is seeking physicians trained and certified in primary care (family practice, internal medicine, pediatrics or emergency medicine) to join newly developing urgent care practice in Marshfield, Wisconsin. Specialists representing all branches of medicine and surgery provide support care and services. A full-time physician will work 45 to 50 hours per week, usually four 12 hour days, including periodic week-ends and holidays. Opportunities exist to combine this practice with an ER practice if desired. Marshfield was recently designated by American Demographics as one of the best small cities in the midwest and America. Wisconsin offers a wonderful four season recreation-oriented lifestyle and this position with fixed hours will afford the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you would like to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director, Physician Staffing, 1000 North Oak Ave, Marshfield, WI 54449, or call, 1-800-826-2345, extension 5376. 5-8/91

BC/BE obstetrician/gynecologist-Door County, Wisconsin. Live in Door County year around. BC/BE OB/GYN to join established BC/GYN in hospital-based practice. Complete facilities available. New LDRP birthing center in modern, progressive 89-bed community hospital. Competitive guaranteed salary, incentive package, malpractice insurance. Attractive benefits. Door County offers exceptional four seasons recreation along Lake Michigan shores, proximity to Milwaukee and Chicago. Top-rated schools. Quality community life for family. Send CV to: Richard C. Murray, MD, 330 South 16th Place, Sturgeon Bay, WI 54235. p5-7/91

Family practice or internal medicine. Riverview Clinic, a 60-member multi-specialty facility has a position available at our regional clinic in Delavan. No night calls or hospitalization responsibility. Excellent lifestyle and benefits in beautiful southern Wisconsin. Send CV to Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 5-7/91

Pleasant family practice available in relaxed Western Illinois community. Proximity to the Mississippi offers abundance of outdoor recreational facilities. Opportunity involves a solo, partnership or group practice; benefits may include an income guarantee, financial incentives, relocation assistance, exceptional call coverage and more. Call 1-800-969-7715, Dan Jones, Gielow/Laske Associates, 306 N. Milwaukee St, Milwaukee, WI 53202. 5/91

Independent medical examinations. All of us in medicine share the goal of leading our discipline, while maintaining a profitable practice. At CHIRON, LTD, physicians enjoy the advantages of professional independence and substantial compensation. CHIRON, LTD, is the largest provider of Independent Medical Examinations (IME) in the state of Wisconsin. Thanks to strong growth, we are seeking experienced board-certified orthopedic surgeons, neurosurgeons, neurologists, and physiatrists. As an independent contractor to CHIRON, LTD, you enjoy the freedom and the flexibility to work full or part-time in our office or receive referrals directly to your office. **Substantial compensation, set your own schedule, supplement your current practice, prompt payment with no discounts, no investment or billing collection, openings for active and retired physicians.** CHIRON'S quality assurance program, under the direction of James M. Huffer, MD, orthopedic surgeon, will provide you with all the necessary support to insure that our excellent level of service standards is maintained. To learn more, please send a curriculum vitae today, or call CHIRON at 608-231-3030 (FAX 608-231-2848). Contact: Michael J. Foley, MS, CRC, Operations Director, CHIRON, LTD, 2870 University Ave, Ste 206, Madison, WI 53705. 5-6/91

West Bend, Wisconsin. seeking full-time and part-time emergency physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, paid malpractice insurance with unlimited tail coverage, benefit package and incentive bonus plan available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 32, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p5/91

A prime family practice awaits you in sunny, metropolitan Phoenix, Arizona. We have additional FP opportunities in picturesque Wisconsin and Illinois. Available benefits include student loan repayment, CME allowance, relocation expense assistance and more. For confidential inquiry, call 1-800-969-7715. Dan Jones, Gielow/Laske Associates, Inc, 306 North Milwaukee St, Milwaukee, WI 53202. 5/91

Lake Winnebago, Wisconsin area. Seeking director, full-time and part-time emergency physicians for low volume 60-bed hospital. Attractive compensation, paid malpractice insurance with unlimited tail coverage and benefit package available. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 32, Traverse City, MI 49684; 1-800-253-1795 in Michigan 1-800-632-3496. p5/91

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; 906-563-9243 or office 906-563-9255. 5/91

Antigo, Wisconsin. Seeking full-time and part-time emergency physicians for moderate volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance with unlimited tail coverage. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 32, Traverse City, MI 49684; 1-800-253-1795 in Michigan 1-800-632-3496. p5/91

RATES: 55 cents per word, with a minimum charge of $25 per ad.

BOXED AD RATES: $30 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg,* copy for the August issue is due July 1.

SEND TO: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Physicians Exchange

Continued

Madison, Wisconsin. Positions available: internal medicine & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Medford, Wisconsin. Seeking director, full-time, and part-time emergency physicians for moderate volume facility located in northern Wisconsin. Excellent compensation and paid malpractice insurance with unlimited tail coverage. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 32, Traverse City MI 49684; 1-800-253-1795 in Michigan 1-800-632-3496. p5/91

Baraboo, Wisconsin. Seeking internist, family practitioner, general surgeon and emergency department physician. Growing practices require additional physicians in a beautiful, growing rural community. Contact Thomas Warwick, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608-356-1400. 5-10/91

Sault Ste Marie. Enjoy the north at its best! Undeveloped beauty, coupled with university sophistication and international flare. Just 45 highway minutes from the lower peninsula. Excellent compensation, back-up and paid malpractice insurance with unlimited tail coverage. Contact: Emergency Consultants, Inc, 2240 S. Airport Rd, Rm 32, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p5/91

Family practice, internal medicine and general surgery practice opportunities. Rural lake country community is seeking the above practitioners to join a busy 13-physician multi-specialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Salary and fringe benefits very liberal. Send curriculum vitae or inquiries to Lake Region Clinic, PC, Attn: Joel Rotvold, PO Box 1100, Devils Lake, North Dakota 58301 or call collect at 701/662-2157 for further information. 5/91

Waukesha. Qualified FPs and internists needed to join busy practices. Give excellent medical care and get quick start-up, rewarding income, shared call and coverage with capable board-certified colleagues, first-class hospital, satisfying lifestyle, thriving community. Contact Amy Palmer, Professional Relations Director, Waukesha Memorial Hospital, 414-544-2120 (toll-free, 1-800-326-2011), in confidence. p5-6/91

St Paul, Minnesota. Established, rapidly growing, four person, primary care internal medicine practice seeks to add BE/BC partner. Affiliated with large multi-specialty group. Excellent benefits and salary. Contact: Nancy Borgstrom, Aspen Medical Group, 1020 Bandana Boulevard W, St Paul, MN 55108; ph 612-641-7185. EOE. 5/91

Emergency medicine. Emergency department director and staff positions are available at several client hospitals in Wisconsin and Michigan. Communities include Watertown and Chippewa Falls, Wisconsin, and Ironwood, Michigan. ED volumes range from low to moderate. Flexible scheduling with 24-hour shifts available. Competitive fees, allowance for professional dues and CME, assistance with relocation expenses are made available to Spectrum independent contract physicians. Director also offered benefit package and annual administrative stipend. For specific details, contact Mallarry Dierkes, Spectrum Emergency Care, PO Box 27352, St Louis, MO 63141; 1-800-325-3982, extension 1029. 5-7/91

Emergency department physician, Wisconsin (Stoughton). Emergency department staff physician Stoughton Hospital expanding to two full-time ED positions supplemented by contract service. 7,000 visits/year ED located in community of 9,000, fifteen miles southeast of Madison metropolitan area. Other responsibilities include departmental administrative activities and employee health. Prefer physicians that are board-prepared or board-certified in emergency medicine or family practice. Competitive compensation package including full benefits as hospital employee and malpractice insurance. Contact Steven J. Novacheck, MD, Medical Director of Emergency Services, 900 Ridge St, Stoughton, WI 53589; ph 608-873-2264. 5/91

Permanent part-time or full-time physicians needed for the Urgent Care/Walk-In Department of our multi-specialty clinic. Please send CV to Administrator, Park Crest Medical Clinic, 2665 South Moorland Rd, New Berlin, WI 53151, or call 414-786-1199. 5/91

Locum tenens physician. Join a comprehensive physician support service with a major medical center in south central Montana. Locum physicians provide primary care coverage (excluding routine OB) for physicians in rural Montana and Wyoming. Assignments vary in length. Reimbursement for expenses, mal-practice, health insurance, CME. Call locum tenens coordinator, 1-800-325-1774, or send CV to 1500 Poly Drive, Suite 103, Billings, MT 59102. 5/91

Dermatologist, psychiatrist, allergist, internal medicine, family practice. A progressive, 126-bed two-hospital system is seeking the above specialties to establish practices in the Iron Mountain area of Michigan's Upper Peninsula. Must be BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully staffed, special diagnostic department. Contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; ph 906-779-4500. 4-5/91

BC/BE internist/family practice physician to join group of three established in NE Wisconsin. Weekday schedule; flexible hours; excellent salary and benefits. Artwich Clinic, Oconto Falls, WI 54154. p4-6/91

Physician Clinical Director
City of Milwaukee

Make an important contribution to community health. Involves substantial sexually transmitted disease (STD) clinical supervision and program planning. Also oversee employee health and serve as consultant on general medical clinic matters. Requires medical degree in adult medicine (Ob/Gyn, internal medicine, emergency medicine, etc) and at least two years of clinical experience with extensive STD involvement. Salary range: $57K to $80K with excellent benefits. Please indicate interest by sending resume to: Dr Dan Carson, City of Milwaukee Personnel, Box CD, Room 706 City Hall, 200 East Wells St, Milwaukee, WI 53202-3554. An affirmative action employer. 5-6/91

Mantiwoc, Wisconsin. The Manitowoc Clinic, an 18-physician multi-specialty group is seeking BC/BE general internists and obstetricians/gynecologists. Excellent practice, financial and quality of life opportunity. Send CV or contact James Robinson, Administrator, 601 Reed Avenue, Box 1270, Manitowoc, WI 54221-1270. Telephone (414) 682-8841. 4-6/91

MANITOWOC CLINIC
601 Reed Avenue, Manitowoc, WI 54220

Physicians Exchange

Continued

Iowa practice opportunity in Estherville. Family physician needed to join established rural clinic. Located close to outdoor recreational areas, offers easy access to larger metropolitan cities in Iowa and Minnesota. Competitive salary and signing bonus available. Opportunity of practice ownership. Contact Bill Tendle, LifeSpan, 800 East 28th St, Minneapolis, MN 55407; ph 1-800-248-4921. 4-6/91

Community of 2,000, 50 miles NE of Minneapolis/St Paul, seeks additional family practitioner. Located on the St Croix River and Minnesota border. Practice consists of 13 family practitioners, 2 internists, 2 general surgeons and 1 orthopaedic surgeon. Many specialists available on a part-time basis. Attached to a 90-bed hospital with comprehensive services available. Very stable medical group with pleasant working conditions in a continuous growth mode. Guaranteed first year salary with second year partnership. Fringes include excellent retirement package and car. Contact Lenny Libis, administrator at 715-483-3221. 4-9/91

Internal medicine physician board-certified/board eligible to join 25 physician multi-specialty group in Winona, Minnesota, with existing ten physician internal medicine department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact: J.B. Knuesel, Administrator, Winona, Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 4-6/91

Family practice, Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multi-specialty groups of thirty-five. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest, family-oriented location offering exceptional four season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in those communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449 or call 1-800-826-2345, extention 5376. 4-7/91

General internal medicine, Marshfield Clinic, 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

General surgeon to join a progressive 12-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 4tfn/91

Help! We need volunteer camp health care staff! Camp Phillip, Wautoma, Wis, is seeking qualified WELS or ELS physicians, registered nurses, or practical nurses to staff our medical office this summer. Volunteer a week, and your child goes free to camp. Medical staff needed for the following weeks: 6/30-7/6; 7/7-7/13;7/21-7/27; and 8/4-8/10. For more information contact: Mr Cliff Schmoldt, Program Director, Rte 3, Box 203, Wautoma, WI 54982; ph 414-787-3680. 4-5/91

Emergency medicine, Marshfield Clinic-Lakeland Center, located in the beautiful Lakeland area of northern Wisconsin, is seeking an ER physician. This individual must be BE/BC in FP, IM, or EM. This opportunity offers a challenging variety of patients, within a multi-specialty group representing thirteen specialties available for back-up. The Lakeland area offers a unique recreation oriented lifestyle and this position with a 48 hour work week will afford you the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you want to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

Experienced BC psychiatrist with interest in the psychological problems of the medically ill. Want to develop adjunctive treatment protocols that integrate both mind/body and psychology of healing models in specific short and long-term caseloads. Programs would be in support of basic medical treatment and include survival strategies for chronic and life-threatening illness. Would like to establish contact with anyone in or near the Milwaukee area having a similar interest or specific need. Contact: Psychiatrist, 1545 West spruce Ct, Milwaukee, WI 53217-1128; ph 414-351-4034. 4-6/91

Minnesota communities seek family physicians. Private practice opportunities in attractive settings offer guarantees plus incentives, benefits, and hospital support. Locate your practice in Minneapolis, Richfield, Hopkins, Eden Prairie, Wayzata, Mound, Montgomery, Monticello, Lakefield, Litchfield, Springfield, or St James. Contact: Jerry Hess, Abbott Northwestern Hospitals, 800 East 28th St, Minneapolis, MN 55407; ph 1-800-248-4921. 3-5/91

Internal medicine - Green Bay, Wisconsin. Thirty-one Dr multi-specialty group, ten Dr IM department. Guaranteed first year salary with incentives plus excellent benefits. Excellent patient base in well respected practice. University community with diverse economic base and excellent schools. Superb quality of life and water and land recreational opportunities. Contact John M. Blackburn, Administrator, West Side Clinic, sc, PO Box 19070, Green Bay WI 54307; ph 414-496-4700. 4-6/91

New Physicians for Wisconsin
is seeking

● Family Physicians ● Internists
and many other specialties

Contact: Karen M. Paulson
UW Office of Rural Health
5721 Odana Road
Madison, WI 53719

608-273-5964 COLLECT
7-12/90;1-6/91

Physicians Exchange

Continued

Family practice. Three-physician group seeks fourth MD(BC/BE) to join growing practice located within one hour of Madison and Milwaukee. Full benefits, first-year salary guarantee. One hundred and two bed community hospital located within one block from office. Send resume to Richard C. Holden, MD, PO Box 49, Watertown, WI 53094; ph 414-261-5204. 4-6/91

Dean Medical Center, a 220+ physician multi-specialty group is actively seeking a BE/BC general internist with interest in pediatrics to work at the Stoughton and Evansville, Wisconsin, offices located approximately 20 miles from Madison. Call would be shared with two internists based in Stoughton. There is also four family practice physicians and one general surgeon located at the Stoughton office, along with full subspecialty support in Madison. Excellent compensation and benefits provided with this position. Please submit CV and letter of introduction to Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715, or call work 608-252-8022 or home 608-276-8989. 4-5/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 2-6/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Family practice opportunity as partner, and eventually to assume a well-established practice with flexibility and potential, and opportunity for surgery and OB if desired. Cooperative backup coverage available. Resort community with a number of industries, centrally located between Chicago, Milwaukee, and Madison. Modern 90-bed hospital. Contact: Glenn A. Smiley, MD, Delavan, WI 53115; ph 414-728-3441. 3-5/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary incentive bonus, plus paid health, life, malpractice, 401K. Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

Beautiful southern Wisconsin. Riverview Clinic, a 60-member multi-specialty clinic in Janesville, is seeking a third general surgeon. Clinic is adjacent to a modern, well-equipped hospital and has three primary care satellites in neighboring communities. Janesville, a city of 53,000, is centrally located between Madison and Milwaukee and close to Chicago. Excellent benefit package and salary guarantee first year with a full partnership thereafter. Send CV to Ronald Karzel, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 2-5/91

Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

Urologist. Beautiful southern Wisconsin. BC/BE urologist to join 60-member multi-specialty clinic adjacent to 250-bed hospital. Community of 55,000 with excellent lifestyle. Good benefits and salary guarantee with full partnership after one year. Send CV to: Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St., Janesville, WI 53545. p2-7/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Family practice or internal medicine. Riverview Clinic, a 60-member multi-specialty facility has a position available at our regional clinic in Delavan. No night call or hospitalization responsibility. Excellent lifestyle and benefits in beautiful southern Wisconsin. Send CV to Stan Gruhn, MD, Riverview Clinic, 580 N Washington St, Janesville, WI 53545. p12/90;1-5/91

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Medical Meetings-Continuing Medical Education

June 1, 1991: The Rush Annual Symposium on Transplantation: Immunologic Aspects of Liver Transplantation, at Rush-Presbyterian-St Luke's Medical Center, Inn at University Village, 625 S Ashland Ave, Chicago. Sponsored by the Section of Transplantation, Dept of General Surgery, Rush-Presbyterian-St Luke's Medical Center. CME credit applied for. Advance registration: 312-942-6242. 5/91

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1991-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1992 - April 23-25: Milwaukee
1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday; the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

Medical Meetings-Continuing Medical Education

June 17-19, 1991: Region V Rural Health Care Conference: Problems, Strategies and Services, at Paper Valley Hotel and Conference Center, Appleton. Sponsored by the US Department of HHS, Region V. Fee: $40. Info: Dave DuPre, Health Care Financing, administration, 312-353-2322. g5/91

July 31 - August 4, 1991: Annual Convention of IDAA at Hyatt Regency Hotel, Vancouver, British Columbia. Info: IDAA 1991, All Destinations Travel, 1290 Homer St, Vancouver, BC, Canada V6B 2Y5; ph 604-683-6966. g4-6/91

September 20-21, 1991: American College of Surgeons - Cancer Management Course, at Department of Surgery, Mayo Clinic, Siebens Medical Education Building, Mayo Clinic, Rochester,Minn. Info: Dr John Donohue or Dr David Nagorney, Mayo Clinic, Department of Surgery, Rochester, MN 55905; ph 507-284-2644 or to register, Ms Clifola Coleman, Cancer Management Course, American College of Surgeons, 55 East Erie St, Chicago, IL 60611-2797; ph 312-664-4050. p5-7/91

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

Nov 7-10, 1991: 10th Annual Scientific Meeting of the American Pain Society at the New Orleans Hilton, New Orleans, La. Info: APS, 5700 Old Orchard Rd, 1st Fl, Skokie, IL 60077; ph 708-966-5595. g4-8/91

AMA

June 23-27, 1991: Annual AMA House of Delegates, Chicago.
December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.

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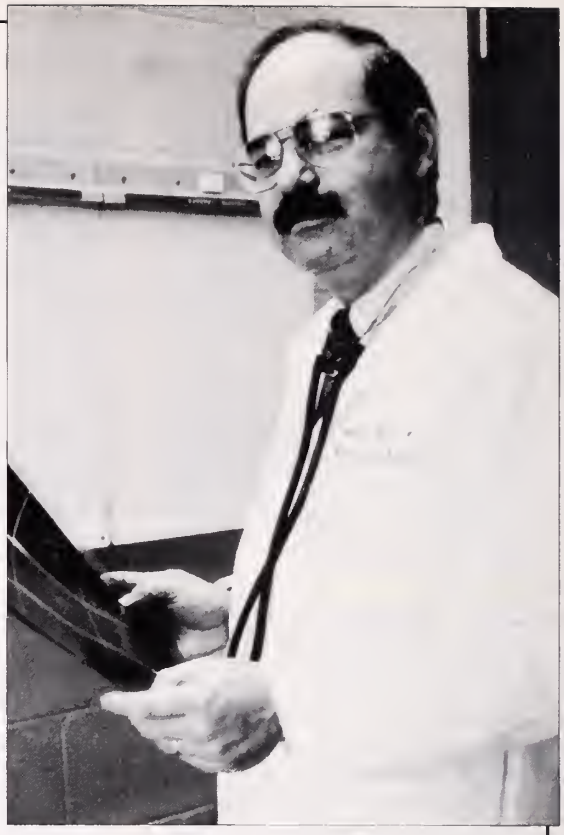

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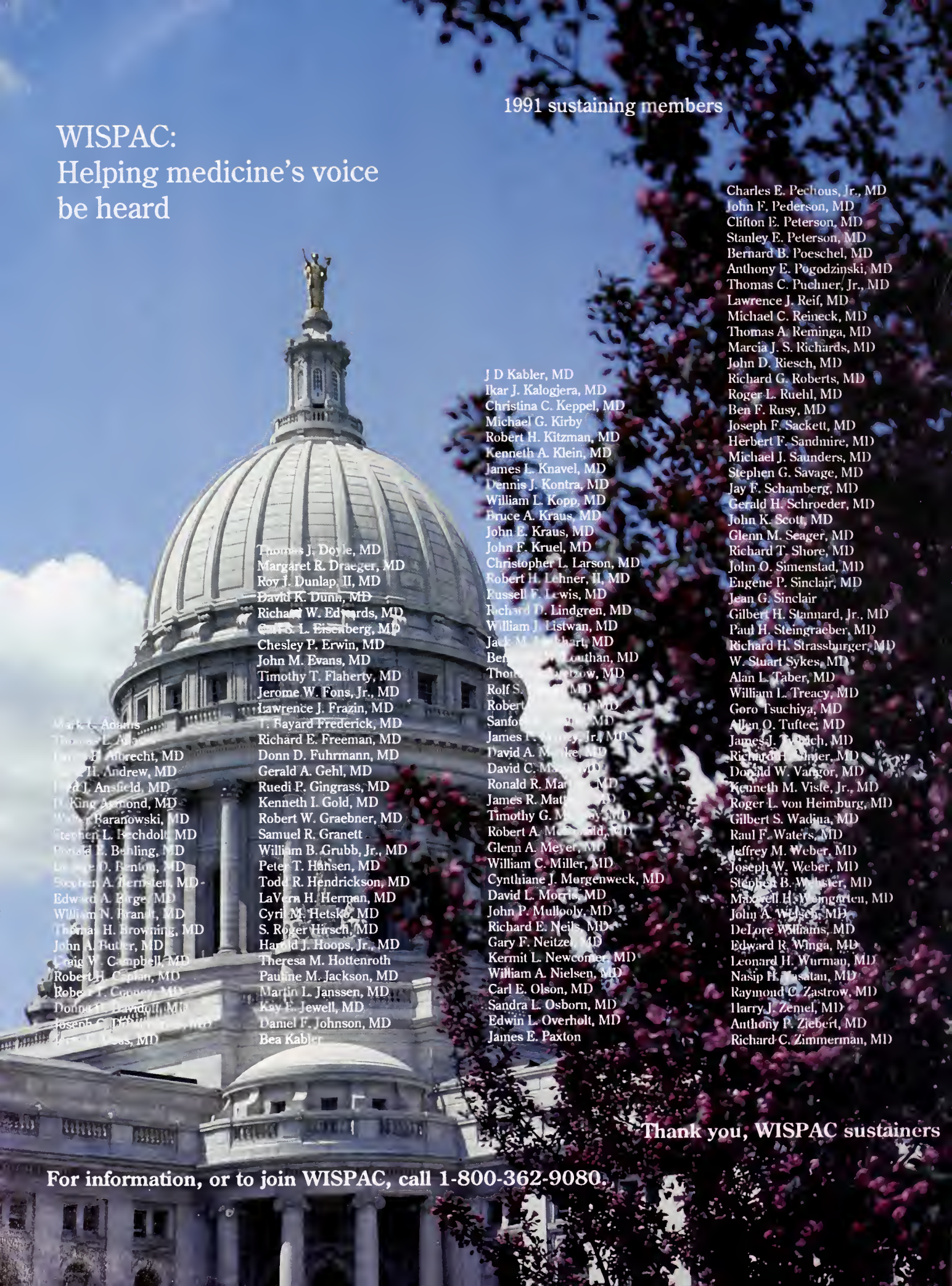

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June 1991 Vol. 90 No. 6

Opinions

263 *President's page*
'Medicina nusquam non est' (medicine is unversal)
by Cyril M. "Kim" Hetsko, MD, Madison
264 *Secretary's report*
A time for action
by Thomas L. Adams, CAE, Madison
266 *Editorials*
A sense of perspective
by Jeffrey H. Lamont, MD, Wausau
269 *Soundings*
The Orderly
by David L. Schiedermayer, MD, Milwaukee

Scientific

275 All-terrain vehicle injuries in central Wisconsin: a continuing problem
by Dean Stueland, MD, and Robert Aldrich, PA-C, Marshfield
279 The importance of bicycle helmets
by Kathleen M. Barkow, MD, Green Bay
281 Elastofibroma dorsi: report of two cases and literature review
by Garfield W. Brown, MD, Ashland
285 Fine needle aspiration biopsy of thyroid nodules
by Robert H. Caplan, MD; Pamela J. Strutt, RN; William A. Kisken, MD; and Susan M. Wester, MD, La Crosse

Socioeconomic

289 Gallup poll measures Wisconsin's opinions on health care
305 *Public health*
Malignant melanoma: trends in Wisconsin, 1980-1989
by Rebecca L. Byers, MD; Paula M. Lantz, MA; Patrick L. Remington, MD; and Jerri Linn Phillips, MS, Madison
308 Individuals pay top share of national medical bills
309 Banker's Life supplemental Medicare insurance policy
309 Kohl and Kasten ask HCFA to postpone CLIA certification fees
310 Wisconsin high court will decide right to die case
310 Wisconsin physician named to HCFA advisory committee

Organizational

311 Physician briefs
314 Obituaries

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Wisconsin Medical Journal

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

'Medicina nusquam non est'

(medicine is universal)

THE GREAT SEAL of the State Medical Society of Wisconsin clearly states the health care goal for Wisconsin in the 1990s: *Medicina nusquam non est.* Literally, "Medicine nowhere not is" or, stated a bit differently, "Medicine is universal." We need to assure universal access to quality health care for the citizens of our state.

We have, by most measures, an excellent health care system in which we can all be justifiably proud. We should keep this basic fact in mind as the nation discusses possible changes in our health care system. Despite some studies suggesting that Wisconsinites weigh too much, smoke too much, and drink too much alcohol, Wisconsin has one of the longest average life expectancies and lowest infant mortality rates in the country. We should take pride in these accomplishments.

As we move further into the 1990s Wisconsin medicine and American medicine are faced with the challenges of building better access to quality medical care in the face of what are perceived as dwindling financial resources.

Everyone says that health care costs are someone else's responsibility and that someone else should pay. All of us tend to be caught up in the phenomenon of pointing elsewhere rather than acknowledging that all of us, regardless of the original causes of the problem, have a role to play in building upon what we have to develop a system that works for us all.

In my inaugural address in Milwaukee, I issued a number of challenges to the various players in the Wisconsin health care arena. This year, I will be exploring these challenges with you.

I challenged the state and federal governments to live up to the promises that they have made. For example, the federal government in the 1960s, and congresses and presidents since then, have created the promise to the American people that when they get old, the government will take care of their health care needs. This has proven to be a hollow promise. Every time they come up with a new service that they will not cover, every time they come up with a new punitive PRO mechanism to arbitrarily and capriciously decide what is unnecessary care, every time they come up with a system like DRGs to ratchet down payments, the government's promises ring more hollow and the state and federal governments are

Continued on next page

Cyril M. "Kim" Hetsko, MD

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Continued from page 263
reneging on their promises.

At the state level, Gov Thompson should live up to the promise he made to this State Medical Society a year ago to adequately fund Medical Assistance for obstetric and pediatric services. Unfortunately, the governor's recent budget proposals have not fulfilled this promise. And the Legislature and governor should live up to the broader commitment of truly providing access to care for all persons covered by Medical Assistance.

Many programs created at the federal and state level have succeeded in providing care, not because of the government that created them, but in spite of that government. To the extent that they have succeeded, it has been because of medicine's collective sense of obligation to care for those in need.

All too often, the federal and state government have relied on the medical profession's moral and ethical creed of providing care to those in need, regardless of their financial resources.

I challenge the government to live up to promises made to both physicians and the patients they serve. Is it any wonder that fewer and fewer of us trust the federal government? We cynically watch $250 billion to $500 billion applied to bailing out the savings and loan industry while being told that the federal budget must be balanced by using RBRVS in ways never intended and by delayed claims processing. Government has had an undistinguished history in recent years.

It is high time that the state and federal governments live up to promises that have been made, and stop making new promises that they cannot keep.

This is the month in which the state budget, with all of its policy ramifications, is likely to be finalized. I urge the members of this Society to contact Gov Thompson's office and their state legislators' offices to and urge them to live up to the promises made to the citizens of Wisconsin. This is especially important in regard to increasing reimbursement for physicians' services provided on behalf of the Medical Assistance patients.

Assurance of universal access to health care is not just a concern of medicine, but a responsibility of all of society. As elected leaders, the governor and Legislature must help fulfill the imperative: *Medicina nusquam non est.* ❑

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Secretary's report
A time for action

JUNE, IF THE LEGISLATURE is anywhere close to being on schedule, is the month of final debate and action on the state budget. The SMS' key contact physicians have been mobilized, but this is a time for extraordinary measures. With that in mind, I'd like to echo the call of your president, Dr Kim Hetsko, and ask you to contact your elected leaders in Madison regarding physician reimbursement for services provided to Medical Assistance (MA) patients.

The key to success in the Capitol is to impress your legislators with the need for equity. Physician reimbursement for MA services has been severely under-funded for years and is lagging far being MA payments to nursing homes, hospitals and HMOs. What we are asking for is simple fairness.

We're also asking for a dose of business sense. Spending MA dollars on obstetrics and gynecology, on the Healthy Start program, and on physician services early in the life cycle saves countless MA dollars at the other end. An ounce of preven-

Continued on page 266

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Continued from page 264

tion is still worth a pound of cure. Introducing MA patients to the health care system early not only allows preventive care to work, it helps these patients learn to make the most of the system and gives the physician better opportunities for teaching healthful lifestyles. Both fiscal and political responsibility dictate that such funds be spent where they will do the most good–where they will bring the greatest return (in terms of good health) on their investment.

There is a moral responsibility here, too. Spending MA dollars early in the life cycle not only saves the taxpayer money, it saves the patient suffering. Preventive care now helps avoid pain later. The moral course of action seems clear.

I realize that I am urging you to do something that runs against the grain of your profession. Traditionally, physicians have not liked to discuss money, and that tradition is admirable. But–as Dr Hetsko noted at the SMS annual meeting–when physicians must sometimes work for as little as $8 an hour while auto mechanics command $48 an hour, priorities are askew and action is appropriate.

Thomas L. Adams, CAE

I have recently had the opportunity to travel the state with leaders of industry and health care to meet with newspaper editors and explain how the problems of health care cost, access and availability may be addressed. Time and time again, we were confronted with flippant references to a national health care system as the cure for what ails the current American system. We did our best to discourage such shallow thinking and encourage the editors to look a little more deeply into the issue. We held up the Medicaid program as an example: no one even remotely familiar with Medicaid can conclude that what we need is another federal program–much less one that is infinitely larger and more complex than the Medicaid debacle.

Read Dr Hetsko's *President's page* (see page 263) and heed his call to action. Pick up your pen or your phone and make yourself heard. ❑

Editorials
A sense of perspective

AN ODD DICHOTOMY exists in many high schools today. One hand, students can choose from a wide array of extracurricular activities. Sports, music, drama, computers, FFA–even the smallest high school can usually find something for everybody. On the other hand, many students don't get a chance to sample a fraction of what's offered. Oh, sure, a few of them have only a narrow spectrum of interests (and you can still be painfully and indelibly labeled "nerd" for the duration of your high school career if you dare come out of the closet with your interest in model railroading, stamp collecting, or ham radio).

Others, however, have a variety of interests and talents and yet are expected to subscribe to a monastic code of devotion to one particular activity through the fanaticism of that activity's faculty advisor. As a group, athletic coaches take the cake in this regard.

Consider, for example, the situation in which a friend of mine finds himself at the hands of his high school coach. This particular student is truly a polymath, with considerable interest and ability in music, the sciences, and sports. Can he exercise his interest in both band and athletics with a little flexibility on the part of each program?

"No problem," says the music faculty.

"No way," says his coach.

My friend says he has been told that if he misses even one athletic event because of a schedule conflict

Continued on page 268

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AIR FORCE

Continued from page 266
with a music event, he will not be allowed to compete for the rest of the season. He says the coach told him that none of the other coaches in his department put up with "sharing" their athletes with music or drama or other extracurricular activities and he shouldn't have to either. Beyond this, my friend says that his interest in music is disparaged openly by the coach.

This sort of behavior on the part of an adult advisor is inexcusable. There is no question that regular attendance and hard work are critical to the success of any group effort, whether it be an athletic team, the drama society, or the concert choir. On the other hand, single-minded devotion is not the real world, even for adults, and certainly shouldn't be for a high school student whose interests and abilities are still being discovered.

Most high school athletic departments fail to address the physical education needs of the majority of their students. Attention and facilities are lavished on the few students who choose to participate in athletics, while lip service is given to developing a physical education program designed to address a student's lifelong need for physical fitness.

Think about it–did any of your high school classmates who started out overweight and out of shape not graduate in the same condition? I didn't think so, and that's a high price to pay for an expensive athletic program. With this in mind, it is important to realize that high school athletic departments too often victimize even those athletes to whom the athletic program is seemingly dedicated.

It happens this way. Many towns attach tremendous and unwarranted importance to the success of high school athletic teams as a source of town pride. Somehow, being the home of the state basketball champs seems to make up for increasing taxes, crime rate, and unemployment. We laugh at two kids exchanging father-threats: "My dad can beat up your dad." "Oh, yeah? Well, *my* dad...." You get the picture. What sounds juvenile coming from two 4-year-olds, however, suddenly seems sensible to most folks when coming from the local town fathers or the sports page. The pressure for the high school team to perform is on.

Unfortunately, too many high school coaches respond to this pressure, not by putting things in their proper perspective, but by feeding into it. Some may feel a "win or die" job-related pressure. I suspect many love the ego trip of being recognized as the local Norman Schwartzkopf of, say, high school basketball. Whatever the reason, high school coaches start acting like their college and professional counterparts–which they aren't–and treating their high school students like college or professional athletes–which they aren't. In this atmosphere, the athletic program overshadows the athlete–and this is wrong because it forces students into a role not designed to benefit them but to satisfy the glory-lust of others.

High school athletes, like other children their age, are looking for role models, templates upon which to forge their expanding interests and abilities. Adolescents seek to bestow the title of "role model" on individuals whom they hope will guide them as they develop.

Responsible adults–parents or teachers–understand the restraint that must be exercised to prevent a role model from becoming the object of hero or cult worship. Unfortunately, too many coaches not only seem to fail to recognize this distinction, but in fact encourage a cult-worshipping attitude in their athletes through such vague but absolute demands as "100% devotion" or by openly ridiculing an athlete's expressed interest in other disciplines.

An adolescent eager to prove himself and be accepted, and attracted by the glamour of high school athletics, can fall easy prey to this "I am the way, the truth and the life" attitude in a coach. The Reverend Jim Jones (remember Jonestown Kool-Aid?) and the genial tutors in a Khmer Rouge re-education center would feel right at home with thinking like this. Motivation of a high school athlete should not require a cloistered life but for athletics, or hero-worshipping of the coach. Such absolute control of mind, body, and spirit has no place in the education of our children.

One other thing: My friend's coach was not only in sports in high school but also sang in the high school concert choir for 3 years. It would not appear that single-minded devotion was demanded of him as a high school student.

Interestingly, he currently teaches in his high school's language department. I wonder how he would feel if the math or science departments demanded "100% devotion" to their subjects at the expense of his. I also wonder if he has really lost sight of the value of a broad-based education in the years since he graduated from high school, and if so, what changed his mind.

–Jeffrey H. Lamont, MD
Wausau ❑

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Soundings

The orderly

It was dark in the room and the orderly, who had sat by the foot of the bed, got up and went out...
–Ernest Hemingway
A Farewell to Arms

He worked nights and it was a hot summer night. He checked on each patient, remembering their names and faces: Frank, the 96-year-old with congestive heart failure; Sherman, with delirium tremens; Hazel, with painful bone cancer; Osborne, the tough guy who liked to kid; Mr Miller, whose urine was being strained for kidney stones; Bill, with broken skull, clavicle, ribs, hip; Ray, with the hernia; Dora, with the carbon monoxide poisoning; Andy, with Alzheimer's, Willard, dying of throat cancer.

He knew each one in many ways. He knew how they sounded when they groaned or snored, for the corridor was quiet and it was easy to hear them. He knew who slept lightly, so he was careful to avoid making noise in their rooms.

Frank, who didn't have any dentures, had tough gums and could somehow chew and grind most kinds of food.

Each nurse had a different approach to Sherman, who had wicked uppercut if he could get his right hand free.

Hazel was nearly terminal with her bone cancer, and he never talked about it in her room unless she spoke of it first. Sometimes, when he was making her bed with her in it, she would ask him how long he thought she had to live. He would always say he didn't know. She seemed satisfied with the answer, and went back thinking, estimating, marking her date on her internal calendar.

Osborne would always kid him about working at night, the only guy with all these female nurses.

Mr Miller, who had a painful kidney stone and required huge amounts of morphine, had only one concern: was he passing the stone yet? It hurt enough to be passing. But when the orderly strained his urine, there was

Continued on next page

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Continued from preceding page
no stone. Mr Miller would sigh and hope for the next time.

Bill was badly hurt in a car accident, but was healing well. Hospital life bored him, so the orderly brought two papers, and the little hospital bookmobile into his room every day.

Ray was the one whose pubic hair he had shaved prior to hernia surgery. When Ray saw the razor in the orderly's hands, he made no effort to conceal his fear. The orderly said, "Relax, we do this almost every day." Ray's surgery went well, but his shaving was difficult because he jumped and twisted the whole time.

Dora came in with carbon monoxide poisoning from an old stove in her trailer and wanted to go home soon.

Andy, with Alzheimer's, was a pleasant man who always shouted that he wanted sauerkraut. When the orderly heard it the first time, he had asked the nurses if he should give Andy some sauerkraut, but the nurses said Andy couldn't eat solids. Andy had a feeding tube and sauerkraut tends to clog them up. He was tempted to give Andy sauerkraut juice, but he knew the juice would go right to Andy's stomach and he wouldn't get the taste. Once, when he had given Andy a small sip of water by mouth, Andy sputtered and choked and started turning blue, so he knew he couldn't give Andy the sauerkraut juice by mouth.

Willard's throat cancer had spread into his neck and was choking off his breathing while eating into his artery. The orderly knew it was a race between the two ways to die, and listened every night to the rattle. One night, the rattle stopped. He walked in the room, sat down on the bed, and felt for the man's pulse. Nothing.

There was a lot to do now. He would have to tell the nurses and they would come, and call the doctor, and the undertaker, and then they would prepare the body for the trip downstairs and out the back door. A lot to do, but for a moment he sat in the dark room.

Then he turned on his flashlight, got up, and went out.

–David L. Schiedermayer, MD
Milwaukee ❑

Dr Humerus?

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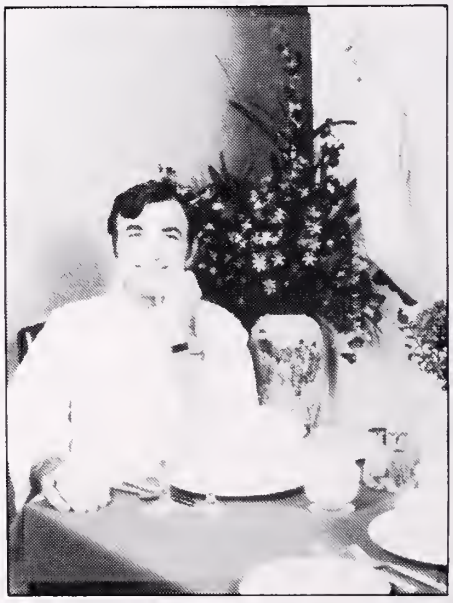

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All-terrain vehicle injuries in central Wisconsin: a continuing problem

Dean Stueland, MD, and Robert Aldrich, PA-C, Marshfield

All-terrain vehicles (ATVs) have become well recognized as associated with injuries. This recognition has resulted in attempts at education and regulation to reduce the number and severity of injuries and number of deaths. The Marshfield Clinic and St Joseph's Hospital surveyed all-terrain vehicle accidents in the Emergency Department in 1985 and again in 1988 and followed these patients for at least 1 year after the injury. Between the two dates, extensive educational and legislative activity had taken place. The actual number of all-terrain vehicle accidents had increased. The characteristics of victims who were involved in all-terrain vehicle accidents did not change. The actual number of accidents associated with three-wheeled ATVs did not appreciably decrease but the number of accidents associated with four-wheeled ATVs did increase. To date, it is not clear that legislative and educational activities are effective in reducing the number of ATV accidents or in changing the pattern of the accidents. *Wis Med J* 1991;90(5):275-278.

ALL-TERRAIN VEHICLES (ATVs) were introduced in the United States in the early 1970s. In addition to use in ranch and farming activities, ATVs have become popular recreational vehicles. By the end of 1987, an estimated 2.5 million ATVs had been sold.[1] These vehicles, however, are also dangerous. According to the United States Consumer Product Safety Commission (CPSC) estimates, more than 340,000 injuries had been associated with the use of ATVs (including almost 1,000 deaths) by 1987.[2]

The CPSC concluded that there were several inherent difficulties with ATVs and made recommendations for action. Subsequently, in 1987, the industry agreed to affix warnings to ATVs and halt the sale of three-wheeled ATVs.[3] Wisconsin, among other states, passed legislation in 1986 and 1987 to regulate their use in an attempt to decrease injuries. For example, the Wisconsin ATV law requires that ATVs only be used on roadways designated as ATV routes unless used exclusively on agricultural and private land. Furthermore, attempts have been made to regulate age use by requiring those under 12 years old to be "accompanied" by a person at least 18.

Despite warnings of danger and legislation to restrict the use of ATVs, the problem of injuries related to ATVs persists. The main purpose of this analysis is to re-examine the problem of ATV accidents to determine if the efforts between 1985 and 1988 had resulted in a significant change in the number or pattern of ATV injuries.

Methods

The Marshfield Clinic/St Joseph's Hospital serves a predominately rural area. The primary service area is central Wisconsin, but the medical complex does also serve as a referral center for much of Wisconsin and the upper peninsula of Michigan. Initial assessment and resuscitation is managed by Emergency Department physicians and nurses with subspecialty backup including surgery, medi-

Dr Stueland is with the Section of Emergency Medicine, and Aldrich with the Section of Neurosurgery, both at the Marshfield Clinic/St Joseph's Hospital. Address reprint requests: Dean Stueland, MD, Section of Emergency Medicine, Marshfield Clinic, 1000 N Oak, Marshfield, WI 54449. Copyright 1991 by the State Medical Society of Wisconsin.

cine, and pediatric specialists and subspecialists available from the attached Marshfield Clinic. There was no appreciable change in the staffing pattern of the Emergency Department between 1985 and 1988 and the pattern of referrals had not knowingly changed between those years. The use of inpatient facilities for observation, however, was felt to be reduced in 1988 as compared to 1985.

In 1985, the Section of Emergency Medicine of the Marshfield Clinic/St Joseph's Hospital began to prospectively identify all ATV accident victims seen. The initial analysis[4] and similar studies[5] have been previously reported. Clinical concern was the problem was still persisting to a substantial degree. In 1988, the section again prospectively identified all ATV accident victims seen in 1 year. Data were abstracted from the Emergency Department record and if follow-up care was required, from the Marshfield Clinic record. In each case, the patient had been followed at least 1 year before abstraction was performed. This analysis compares to characteristics of those victims seen in these 2 years and reflects our experience following extensive media exposure and early state and federal regulatory efforts.

Finally, to control for the possibility of a change in referral pattern, reference is made to a previously defined primary catchment area around Marshfield.[6] Victims also were noted to be either within or outside that catchment area.

The data was entered into a microcomputer system and the frequencies were obtained on SPSS/PC. Analysis is presented as frequencies and percentages.

Results

The total number of persons injured, sex and residence is shown (Table 1). From 1985 to 1988, there has been a 38% increase in the number of ATV accident victims, while the number of Emergency Department visits grew by only 26%. There was, therefore, a disproportionate increase in the number of ATV related visits over the general Emergency Department volume.

Although the percentage within the primary catchment area fell from 64% of the total to 56%, the actual number from within the primary catchment area increased from 29 to 35. Those from outside the primary catchment area increased from 16 to 27.

The percentage of victims who were males was 84% in 1985 and 89% in 1988 reflecting that males continue to suffer most of the injuries related to ATV use.

Although more than than 80% of the residents live in a rural area, in both years, the majority of the victims actually only lived in a rural nonfarm location and were not farmers.

The breakdown by month is shown (Fig 1). In both 1985 and 1988, the peak of activity was in May through September. In both years, however, there continued to be activity throughout the year including the fall and winter months. In fact, in 1988 there was an increased number of accidents as compared to 1985 in all months except May, July, and November.

The breakdown of the number of victims by age is shown (Fig 2). In both years, the age range at highest risk was the young adults. In 1988, the peak of age is slightly later. At the same time, however, there seems to be an increased number of children also injured in 1988. In 1988, there were two victims under the age of 6 and 19 patients (30%) were younger than 16 years.

Factors possible contributing to the accident are shown (Table 2). Although the percentage of accidents due to three-wheelers has fallen from 1985 to 1988, the actual number has fallen only slightly as shown (Table 2). At the same time, there has been

Table 1.–Comparison of ATV injury accident victim demographics, 1985 and 1988.

	1985	1988
Number of victims*	45	62
Sex		
males	38 (84%)	55 (89%)
females	7 (16%)	7 (11%)
Residence		
farm	12 (27%)	16 (26%)
rural non-farm	25 (56%)	32 (52%)
urban	6 (13%)	11 (18%)
unknown	2	3
Number of emergency department visits	20,690	26,152
Primary catchment area		
within	29 (64%)	35 (56%)
outside	16 (36%)	27 (44%)

*In both 1985 and 1988, one victim entered into the study was injured in a head-on collision in which the other victim was declared dead at the scene and not entered into the study. The number of persons injured in each year also includes one victim who was injured twice within the same calendar year; both events are counted.

a five-fold increase in the number of injuries related to the four-wheeled vehicles.

The number of cases in which there was a history of loss of consciousness at the scene was reported to be less in 1988 than in 1985. In addition, the number of cases in which there was a need for a prompt operation was less in 1988 than in 1985. Furthermore, the percentage of cases in which a passenger is present also was reduced in 1988. A higher percentage of victims, however, were wearing helmets in 1985 than in 1988 and alcohol seemed to be involved to a greater percentage of cases in 1988 as compared to 1985.

In both 1985 and 1988, recreational use was by far the dominant use of the victims suffering ATV accidents. In fact, the percentage used for work is actually less than the percentage used on a farm, implying that most of those used on the farm also were used for recreational purposes.

The actual injuries seen in 1985 and 1988 are shown (Fig 3). The similarity between the two years is striking. Although by history, there are fewer cases of loss of consciousness in 1988 than in 1985 (Table 2), in fact, the number of patients that were medically felt to have significant head injuries is unchanged.

To better understand the types and mechanisms of more severe injuries, the cases that required inpatient treatment were evaluated more extensively. In both years, there were 11 victims. The victims are scattered evenly throughout the months of the year. In all cases in 1985, the victim was riding a three-wheeler, but 6 of the 11 cases in 1988 occurred to victims riding four-wheeled vehicles. In both years, all the hospitalized victims were male. The youngest hospitalized victim in 1985 was age 9, and in 1988 age 5. In both years, two of the hospitalized victims were younger than 12 years old. Although some riders were injured when the ATV hit another vehicle or structure, most were injured when the vehicle flipped or the rider was thrown off the vehicle. The diagnosis of hospitalized victims was usually extremity fracture or head injury.

During the same period, the Wisconsin Department of Health and Social Services has monitored the number of deaths per year. The number of deaths in the affected years are as follows: 1985, 5; 1986, 9; 1987, 10; 1988, 5; 1989, 8.[7]

Discussion

The major observation in comparing 1988 to 1985 is the persistence of ATV accidents and injuries. The increase is from both within and outside the primary catchment area. Since the population within the primary catchment area has been stable, this probably represents both an increased number of referrals plus an increased incidence within the primary treatment area.

Although the preliminary consent agreement[3] was signed on Dec 30, 1987, the implementation had actually begun earlier and early positive effects could have been shown in 1988. The percentage of victims who were wearing a helmet was actually decreased in 1988 as compared to 1985 and the percentage in which alcohol was involved was actually increased. On the other hand, a lower percentage of accidents involved vehicles carrying a passenger. The overall impression, however, is that there was no improvement in safety behavior in 1988 compared to 1985.

ATV accidents continue to be primarily a male problem. This has been underscored by other studies related to accidents and specifically ATV accidents.[8,9,10]

Although originally developed for work, the ATV is primarily used for recreational purposes at the time of injury in both years.

There is a definite seasonal variation with many more accidents occurring during the summer months than during the winter months. ATV vehicles can, however, be used throughout the year, as is reflected by the breakdown by month. In addition in 1988, 9 of 12 months had more accidents in 1985 with no apparent change in the distribution of the seasonality of the injuries. The seasonal variation has been noted in other states with cold winters such as Maine[8] and Minnesota,[11] but not in locations where the climate is conducive to outdoor activity throughout the year, such as in southern California.[12]

Although both the three- and four-wheeled vehicles were felt to be intrinsically unstable, the three-wheeled vehicle does appear to be more unstable.[10,13,14] The stability of the four-wheeled vehicle may be overcome with a larger engine. Since the three-wheeled vehicles are no longer manufactured, the number of three-wheeled ATVs would be expected to fall with a subsequent reduction in the number of injuries related to their use. It appears, however, that owners continue to use their three-wheeled ATVs, and that ATV accidents continue to occur. In Wisconsin in 1989, 20,000 of the 50,000 registered ATVs were three-wheeled ATVs.[15] Although they

Table 2.–Comparison of injury accident victim use of ATVs, 1985 and 1988.

	1985	1988
Type of ATV		
3-wheeler	40 (89%)	38 (61%)
4-wheeler	5 (11%)	24 (39%)
History of loss of consciousness	8 (18%)	5 (8%)
Passenger present	14 (31%)	8 (13%)
Wearing helmet	10 (22%)	9 (14%)
Alcohol involved	3 (6.7%)	11 (18%)
Recreational use	43 (96%)	59 (93%)
Surgery required	11 (24%)	7 (11%)

represent only 40% of the registered ATVs in Wisconsin, the three-wheeled ATVs are associated with more than 60% of the accidents in this series. Therefore, the three-wheeled ATV may be slightly more unstable than the four-wheeled ATV.

A disturbing feature that persists in both 1985 and 1988 is the significant number of children involved in ATV injuries. In 1988, the peak age of injury is slightly older than in 1985. Nevertheless, in most childhood age ranges, the number of victims in 1985 and 1988 is nearly identical. ATVs seem deceptively easy to use and children are often allowed to use them. The physical and neuromuscular facilities needed to control an ATV, however, are generally more than that possessed by children.[16]

Similar to other studies,[13] the mechanism of injuries in those patients who were hospitalized was most often due to falls from or being thrown from the vehicle. Consequently, the majority of the injuries were fractures or head injuries. In those less seriously injured and treated as out-patients, the majority of the injuries continued to be fractures and soft tissue extremity injuries. Nevertheless, chest injuries and abdominal injuries do contribute substantially to the morbidity.[9,11,12]

Although no deaths were recorded in the patients who were admitted from the Emergency Department, in both years there were victims who died at the scene and were not entered into our series. Likewise, the state-wide surveillance also shows a persistence in the number of deaths from ATVs without a perceivable change.

Summary

Injury surveillance in the Emergency Department of the Marshfield Clinic/St Joseph's Hospital was used to monitor ATV accidents in central Wisconsin. Despite the publicity given to the dangers inherent in ATV use, there is a persistence and actually an increase in the number of accidents seen. Although the three-wheeled ATV is no longer being manufactured or sold new, the three-wheeled ATV is still more often associated with injuries than the four-wheeled ATV. People of all age ranges are victims of ATV accidents; while young adults are the most common victims, children are often injured as well. Unsafe habits which are risk factors for injury persist and include riding with a passenger, drinking while driving, or riding without a helmet.

An emergency department that services an area where ATV injuries occur needs to be prepared for a wide range of injuries associated with sudden deceleration or blunt trauma.[11,12] Despite the switch from three-wheeled to four-wheeled ATVs and the safety messages, this surveillance indicates that there has been no significant change in the mechanism of injury or the spectrum of injuries that result from ATV accidents. This is consistent with the previously reported summary.[17]

Efforts to manufacture a safer ATV continue. Additional efforts including education, training, and legislative regulation also continue. There is not yet, however, evidence that there has been any reduction in the rate or severity of injuries.

Acknowledgment

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References

1. Kitzes WF. ATVs–The hidden danger. *Law, Medicine and Health Care* 1989;17:86-93.
2. Newman R, Schachter L. Update of ATV Deaths and Injuries, US Product Safety Commission, Feb 11, 1988.
3. United States of America v American Honda Motor Co, Inc, et al. Preliminary Consent Agreement, Dec 30, 1987.
4. Shallman RW, Aldrich RE, Kelman DB, et al. Three-and four-wheeled all-terrain vehicle injuries: One year's experience in a large rural medical center. *Wis Med J* 1986;85:15-17.
5. Cogbill TH, Landercasper J, Strutt PJ, et al. The three-wheeled motorcycle--A new mechanism of serious injury. *Wis Med J* 1986;85:18-20.
6. Desbiens NA, Broste SK, Follen MA, et al. A population–based study of the prevalence and outcome of serious illnesses in adults. *Jrnl of Clin Epidemiology* (in press).
7. Krantz FP. Research Analyst for the State of Wisconsin, Department of Health and Social Services.
8. Margolis JL. All-terrain vehicle accidents in Maine. 1988 Mar;28:395-397.
9. McDonald WG, Stribling JG. Trauma associated with tree-sheeled recreation vehicles. *Jrnal of Mississippi Med Assoc* 1983;24:121-123.
10. Percy EC, Duffy JP. All-terrain vehicle injuries: A sport out of control. *Western Jrnl Med* 1989;150:296-299.
11. Adams BE. Trauma caused by three-wheeled motor vehicles–An unrecognized epidemic? *Annals of Emer Med* 1986;15:1288-1292.
12. Trager GW, Grayman G, Hoss S. All-terrain vehicle accidents: The experience of one hospital located near a major recreational area. *Ann Emerg Med* 1986;15:1293-1296.
13. Haynes CD, Stroud, SD, Thompson CE. The three-wheeler (adult tricycle): An unstable, dangerous machine. *Jrnl of Trauma* 1986;26:643-648.
14. Stevens WS, Rodgers BM, Newman BM. Pediatric trauma associated with all-terrain vehicles. *J Pediatr* 1986;109-25-29.
15. Polasek J. Fiscal estimates regarding ATV restrictions in support of 1989 Senate Bill 285. Department of Natural Resources of Wisconsin.
16. Sneed RC, Stovec SL, Fine PR. Spinal cord injury associated with all-terrain vehicle accidents. *Pediatrics* 1986;77:271-274.
17. Cogbill TH. The toll taken by all-terrain vehicles climbs. *Wis Med J 1990;89:250-254.*

The importance of bicycle helmets

Kathleen M. Barkow, MD, Green Bay

From 1984 to 1988, Wisconsin experienced an average of 14 fatalities and 1,917 non-fatal injuries annually due to bicycle-motor vehicle crashes. Children aged 0 to 14 years accounted for 47% of the injuries and 48% of the fatalities. Bicyclist injuries not involving motor vehicles are substantial but largely undocumented.

Nationally, an estimated 95% of non-fatal bicyclist injuries and 18% of bicyclist fatalities do not involve a motor vehicle and are not reflected in state traffic statistics. For instance, the Children's Hospital of Wisconsin reported treating approximately 3,700 bicycle related injuries in 1988 and only 2,100 bicycle-motor vehicle crashes were reported statewide during this same period.

The Consumer Product Safety Commission estimates that 75% of death and permanent disabilities to bicyclists involve head injuries. A Seattle area study indicated that helmeted bicyclists reduce the risk of head injury by 85% and the risk of brain injury by 88% (*N Eng J Med* 1989;320(21)). Based on the above information, the American Academy of Pediatrics makes the following recommendations:

- Pediatricians should inform parents and patients of the importance of wearing bicycle helmets and the dangers of riding without a helmet.
- Retail outlets should be urged to carry approved, inexpensive helmets that are available at the time of purchase of a bicycle.
- The Consumer Product Safety Commission should develop mandatory uniform safety standards for bicycle helmets.
- Coalitions of physicians, parent and community leaders should be encouraged to develop and support community based programs to promote bicycle safety and helmet usage.
- The popular media should be urged to depict the helmeted bicycle rider on television, in advertisements and in promotional materials.

The Wisconsin Chapter of the American Academy of Pediatrics created the task force on bicycle helmet safety in 1989. Our initial thrust in this campaign is the education of primary care physicians regarding the importance of educating their patient's parents and patients about the use of bicycle helmets. It was shown in the Harbor View study that when discount coupons were offered through numerous sites, including physicians offices, stores, and schools, the largest percentage of coupons that were redeemed for bicycle helmets were from physicians offices. Below is a table showing what physicians can do to promote bicycle helmet use and the critical ages for intervention. Free brochures, coloring books and other educational material regarding bicycle helmets and bicycle safety are available through the Wisconsin Department of Transportation. An excellent video, appropriate for showing in your waiting rooms, on bicycle helmet safety and other bicycle helmet materials, including discount coupons, are available by calling 1-800-765-TIPP.

If any physician would have interest in developing a community program or would have questions regarding bicycle helmets, please feel free to contact myself and I will be glad to offer assistance in this area, along with the other members of the task force.

What physicians can do

(From the Harborview Injury Prevention and Research Center)

- Convince your patients who are parents about the hazards of bicycle riding, the need to prevent head injury and the importance of wearing helmets, for themselves and their children.
- Suggest to parents: "Getting your child to wear a helmet is the single most effective thing you can do to make your youngster safe on his/her bike,: and "Bike crashes can happen anywhere, not just on streets."
- Share any personal stories you know that may illustrate the need for helmets.
- Answer the common question: "Which helmet should I get for my child?" Any helmet that has a label stating that it meets the ANSI or Snell Standard, and that fits well, is adequate. A hard outer shell provides somewhat more protection, especially from puncture.
- Speak directly with children you see about the importance of bicycle helmet use. Ask the child: "Did you wear a helmet the last time you rode your bike?" "What's inside your head; what does your brain do for you?" "Do you want to grow up smart?"
- Reward the children who tell you that they wear helmets with small prizes, such as stickers.
- Encourage the use of helmets from the time that children begin to ride bikes themselves, or are carried on parent's bikes. (The latter practice is not to be encouraged.) This enables children to form a habit of

Dr Barkow is with the Webster Clinic in Green Bay. Reprint requests to: Kathleen M. Barkow, MD, 900 S Webster Ave, Green Bay, WI 54301. Copyright 1991 by the State Medical Society of Wisconsin.

helmet use before they get used to riding bare-headed.

- Help parents understand that they are being good parents when they insist that their children wear their helmets–and require that they wear them every time they ride. Also make them aware of the need for children to learn the rules of the road before riding on streets.
- Help parents who also ride bikes realize that their personal helmet use not only protects them, but also sets a model for the behavior that they want their children to follow.
- Supply pamphlets or other educational materials to parents. Put up posters in waiting areas and examining rooms. Keep a kid's size helmet in the waiting room for children to try on.
- Educate your colleagues through a grand rounds presentation or local medical society publication.
- Initiate or lend your support to local campaigns to promote helmet use and bike safety.

Critical ages for intervention

1 year: Parents carry babies in bike carriers; helmets must be used, although bike carriers are not recommended.

3 years: Children riding tricycles, big wheels; child can begin wearing helmet, to get the habit of regular use.

5 years: Children begin riding bicycles; critical time for helmet use to begin.

8 years: Children become more subject to peer pressure; kids need positive reinforcement to start or continue use.

12 years: Peer pressure escalates; positive reinforcement needed once again.❑

A call for papers

Because the *Wisconsin Medical Journal* is dedicated to medicine as it is practiced in this state, it offers Wisconsin physicians both their best opportunity for scientific publishing and the best audience for their work. The *WMJ* editorial board extends its invitation to all Wisconsin physicians to submit papers for consideration. The *WMJ* is a peer-reviewed scientific journal published monthly by the SMS and indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts. Richard D. Sautter, MD, of Marshfield is the medical editor and chair of the Editorial Board.

Letters to the editor, soundings pieces (poetry, first-person accounts, etc), and socioeconomic articles are also welcome.

See page 272 for author's instructions.

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Elastofibroma dorsi: report of two cases and literature review

Garfield W. Brown, MD, Ashland

Two cases of elastofibroma dorsi are added to the 125 non-Asian cases reported in the last 31 years. Rapid growth followed by spontaneous total regression is reported for the first time. Confirmation of these observations by others and tissue confirmation are encouraged. Physician awareness of elastofibromas may reveal a higher incidence of occurrence and help avoid unnecessarily radical surgery. A comprehensive review of the literature discloses several current misconceptions. *Wis Med J* 1991;90(6):281-284.

Case presentations

Case I. A vigorous, thin, 82-year-old caucasian female seen in May 1987 complained of a non-painful mass first noted 6 weeks earlier. She thought it might be related to her quilting hobby. A firm, rubbery, 9 cm mass located just medial to the lower tip of the right scapula was readily demonstrated by abduction of the right arm. The skin and subcutaneous fat overlying the mass was freely mobile and seemed normal in all respects with the exception of the surface protrusion caused by the underlying mass. On palpation, the mass felt to be within or beneath the muscles attached to the scapula. The remaining history, physical examination, laboratory tests, and chest film were normal. An 8 cm x 6 cm x 2 cm mass adherent to the ribs, was excised under general anesthesia because sarcoma was suspected. The histologic diagnosis was elastofibroma dorsi. Recovery was uneventful. She had no other elastofibroma lesions. She had no known relatives with subcutaneous tumors of any kind.

Case II. An unrelated, thin, 81-year-old caucasian male was seen in September 1987 for evaluation of a seborrheic keratosis on his back. During examination an un-associated, asymptomatic 8 cm x 10 cm ovoid mass was found adjacent to the lower edge of his left scapula. Skin and subcutaneous tissues were entirely normal as in the first case. He had no other masses and none had been removed previously. While right-handed, he used a cane in his left-hand because of degenerative arthritis in his right hip. Careful examination of his right periscapular area showed no abnormalities. The mass, a 6.5 cm x 5 cm x 4 cm elastofibroma, was excised under general anesthesia.

Four months later, during examination for an unrelated complaint a new, asymptomatic 6 cm mass just medial to the tip of the right scapula was found. The new contralateral mass was a mirror image of his prior elastofibroma and had virtually identical physical findings. The new mass had not been present 4 months earlier when it specifically had been sought and, thus, had grown to about 6 cm size in 4 months or less. Because of the biopsy-proven diagnosis of the prior lesion and the typical characteristics and location of the new periscapular mass, we photographed but did not biopsy or remove the new mass. This was done, in part, at the patient's request, but with our concurrence following the precedent set by Nagamine.[1]

In December 1990, the patient was traced and re-examined. The right periscapular lesion was now gone. His weight was unchanged from 165 lbs and, as previously, he had very little subcutaneous back fat. He again had no evidence of any other subcutaneous or cutaneous masses. Because regression had not previously been reported, the old photographs were examined and comparable pictures of his back were again taken. These showed nevi in the same locations, but also demonstrated that the obvious protrusion caused by the mass deep to one of the nevi was now gone (Figs 1 and 2).

At 84 and living alone, he had been physically very inactive for the past year. Because of pain in his left hip due to a fall, he now required bilateral canes. He had done very heavy manual labor during his adult working years but was now quite frail. He had no known relatives with subcutaneous tumors of any kind.

Microscopy of both excised tumors showed the typical H and E appearance of elastofibroma consisting of a dense background of eosinophilic staining collagen with scattered islands of fat. There was sparse cellularity and little mitotic activity. The lesions had no capsules and encroached upon and infiltrated into surrounding soft tissues. Verhoff's Van Gieson staining highlighted the "swollen" elastic fibers against a background of collagen. The elastic fibers often had a branched and beaded appearance. In some areas aggregates of separate globules or beads of elastin staining material were present (Fig 3).

Discussion

Since the four patients originally described by Järvi in 1959 and first published by him in 1961,[2] approximately 335 cases have been described worldwide. In the first 21 years 91 cases were reported and then in 1982 Nagamine[1] published a startling series of 170 cases from the Okinawa Prefecture. These consisted of 136 biopsied by him and 34 referred tis-

Dr Brown is a general surgeon recently retired from his Ashland practice. Reprint requests to: Garfield W. Brown, MD, 1214 Chapple Ave, Ashland, WI 54806. Copyright 1991 by the State Medical Society of Wisconsin.

Fig 1.–Patient's back showing bulge at right medial inferior scapular border. Note the nevus on the skin overlying the bulge. Photo taken January 1988.

sue specimens examined by him. In an addendum, he reported another 44 cases accumulated between submission of his manuscript and publication. His personal experience thus amounted to 214 of 305 cases reported to that time. Since 1982, approximately 30 additional cases have been reported in the Western literature.

Elastofibroma dorsi was so named by Järvi because in his patients the tumor's characteristic location was at the medial inferior border of the scapula. Subsequently, other less common tumor sites were identified. Diagnosis is aided by the typical lesion's physical character and location. Palpation is facilitated by having the patient abduct her or his arms to swing the scapulae laterally. Characteristically, the mass is ovoid and flattened with the long axis of its somewhat indistinct borders oriented craniocaudally. Although the mass itself is not tender, it is a potential cause of either localized back and shoulder pain or a painless "clicking" sensation in the region of the scapula. On palpation, the mass is invariably not fixed to the skin and its consistency is indistinguishable from that of a fibro or liposarcoma.

Located deep to the latissimus dorsi, rhomboid, and serratus anterior muscles and lacking a capsule the tumor infiltrates the surrounding tissues. It is often firmly adherent to the periscapular and thoracic fascia as well as to the periosteum of the ribs. MRI and CAT scans have shown no specific identifying characteristics and typically will only reveal the presence of the mass lesion with indistinct borders and an absence of fat planes between tissue structures. The tumor does not exhibit malignant mitotic activity nor does it metastasize. Despite the fact that it may inadvertently be incompletely excised due to its locally infiltrative behavior, only one infraolecranon tumor has been reported to have recurred.[1]

Järvi and others[1,2,4] have felt that the lesion is a "pseudotumor" and is degenerative in etiology being caused by friction of the scapula against the ribs during heavy work or exercise. A preponderance of tumors occur on the right side and among heavy laborers. While one of our cases, by virtue of cane use, could be considered to have had possible severe chest wall-scapular friction, the other patient did considerable handwork (quilting) involving frequent shoulder girdle movement. Both patients were thin, having little tissue plane fat. Initial cases reported in the literature involved only older persons, and some later articles stated that only older people are affected, but patients as young as 6 years old have subsequently been documented.[3]

Elastofibroma dorsi occurs in women several times more frequently than in men.[1] Most authors describe the growth as slow. To our knowledge, while there are scattered patient reports of rapid growth prior to seeing their physician, no growth during ongoing care–and certainly no observation of tumor regression–has previously been reported.

In Nagamine's total series[1] 32.3% of 170 cases occurred within family lines. On Tonaki Island, 66% of the 32 cases had a family occurrence. Cases with familial association did not occur earlier in life or tend toward multiple lesions. The Okinowa Prefecture cluster of cases among people of Japanese extraction may imply a genetic predisposition, a local inciting agent, or both. Nagamine reported on one patient with four lateral thoracic, one periscapular and two infraolecranon lesions.[1] Numerous other reports of multiple site involvement as well as a report of associated visceral involvement exist. No association with malignancy or malignant

transformation of the tumor has been shown.

Most patients have periscapular lesions either alone or in combination with a secondary lesion. Case reports involving other sites include: infraolecranon, deltoid, ischial, lateral thoracic wall, trochanteric, inguinal, plantar, gastric, scleral, axillary, intraspinal, intracranial, hand, foot, and mesenteric sites. The histology and clinical course of lesions reported in the periscapular, infraolecranon, deltoid, ischial and trochanteric areas, stomach, omentum, hand, and foot are similar. The gastric lesion in addition to its typical histology and subsequent biologic behavior was found in a patient with bilateral elastofibroma dorsi.[5] The visceral locations are significant since they demonstrate that non-musculoskeletal sites can be involved and that factors other than mechanical friction may be involved in the tumor's etiology.

The other reports appear to represent lesions with marked elastic and collagen components but differ in other significant characteristics from more classic elastofibromas. An important example of the latter is Deutsch's[6] reported treatment in 1974 of an axillary elastofibroma by radiotherapy. The tumor he treated was located in the right axilla, invaded the pleural space, and caused weight loss. As the lesion began to grow out of the biopsy site in a fungating fashion his patient "began to fail." Radiotherapy caused lesion regression and the patient improved. Follow-up was limited to 1 year. In view of the atypical characteristics such as pleural invasion, fungating growth from the biopsy site, and a significant metabolic influence upon the host, the behavior of the lesion is atypical for an elastofibroma. That single case, however, continues to be cited in recent papers and authoritative texts as the basis for recommending radiotherapy as an alternative to surgical excision.[7]

Lesions reported in the spinal canal, brain, and eye have histologic and other characteristics which are atypical of the disease and remain unexplained. Papillary "elastofibromas" of the cardiac valves and septum are histologically quite different and are probably not related to the condition.

Fig 2.–Comparable photo taken in December 1990. Nevus marks spot. The bulge and tumor are gone.

Etiology

Currently, several theories of etiology exist. Järvi and Länsimies conducted an autopsy study of 235 consecutive Finnish autopsies showing microscopic evidence of "elastofibrotic change" in 24.4% of females and 11.2% of males over 55 years of age.[8] Järvi concluded that "pseudotumor" tissue changes were "reactive degeneration" and "hypertrophy" secondary to friction of the scapula against the chest wall. In the only other necropsy study Barr[9] was unable to find any evidence of periscapular changes in 25 autopsies. Some have argued that since friction would appear to be an almost universal phenomenon this theory fails to explain the relative rarity of these lesions. If these lesions can spontaneously regress, however, as our case reported herein implies, then this fact combined with the location and asymptomatic nature of the tumors may, in part, explain the rarity of reports.

Nakamura, et al[10] performed biochemical analysis of an elastofibroma following elastase digestion and concluded that elastofibroma contained increased amounts of the cross-linking amino acids desmosine, isodesmosine, and lysinonorleucine.

Immunohistochemical studies by Madri, et al,[11] performed on a single "classical" tumor, showed the presence of types 1 and 3 collagen found

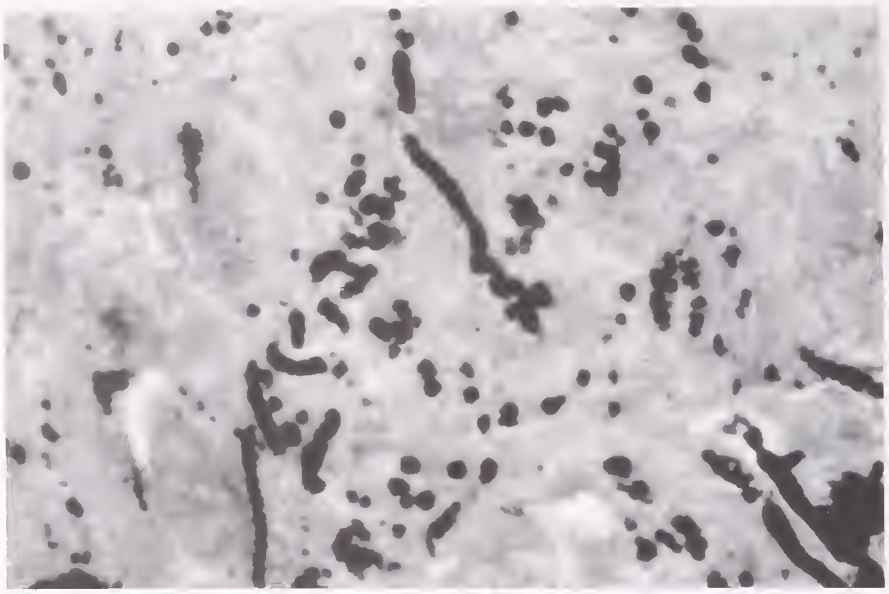

Fig 3.–Verhoff Van Gieson elastic stain 400x.

in skin, bone, blood vessels, and the interstitium of parenchymal organs. In addition, and surprisingly, he also found type 2 collage normally found only in cartilage, cornea, and embryonic neuroretinal cells. Collagen type switching has been documented in cell cultures as a result of viral and chemical agents, in malignant neoplasms, and in benign inflammatory and reparative processes. Madri postulates these lesions may represent benign neoplasms genetically expressing a type of collagen not found in normal reparative tissue. As such one would not expect them to regress spontaneously.

Rose, et al,[12] demonstrated that both fibroblasts and myoblasts have the potential to form elastic fibers. The fibers are assembled outside cells by first laying down a matrix of fibrils upon and within which the elastin is deposited. The unique amino acid composition and type of collagen in elastofibromas combined with the mechanism of formation of elastic fibers outside the cell walls could imply that the globular collections of elastin, the beaded and large elastic fiber size, the discontinuity of fibers and their apparent abnormal construction could be the result of metaplasia rather than "elastotic degeneration and/or hypertrophy."

The familial clustering of cases, the increased incidence in females and the elderly, the tendency for lesions to be multiple, asynchronous, with differing growth rates and sites, and now the apparent regression of a clinically typical lesion need to be addressed in a final explanation of etiology. The present case report of the appearance and regression of a typical periscapular lesion needs verification by other observers. Needle biopsies of secondary (or primary) lesions in patients with elastofibroma, a procedure previously felt unnecessary, would provide tissue confirmation of mass identity. Any later evidence of "regression" would be based on firm ground. Serial needle biopsies may assist in explaining the tumor's etiology.

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References

1. Nagamine N, Nohara Y, Ito E. Elastofibroma in Okinawa: A clinicopathologic study of 170 cases. *Cancer* 1982;50:1794-1805.
2. Järvi OH, Saxen AE. Elastofibroma dorsi. *Acta Pathol Microbiol Scand* 1961 (Suppl)144:83-84.
3. Marin ML, Perzin KH, Markowitz AM. Elastofibroma dorsi: Benign chest wall tumor. *J Thorac Cardiovasc Surg* 1989;98:234-238.
4. Mirra JM, Straub LR, Järvi OH. Elastofibroma of the deltoid: A case report. *Cancer* 1974;33:234-238.
5. Enjoji M, Sumiyoshi K, Sueyoshi K. Elastofibromatous lesion of the stomach in a patient with elastofribroma dorsi.*Am J Surg Pathol* 1985;9:233-237.
6. Deutsch GP. Elastofibroma dorsalis treated by radiotherapy. *Brit J Radiol* 1974;47:621-623.
7. Enzinger FM, Weiss SW. Soft Tissue Tumors. St Louis: CV Mosby Company 1988:122-127.
8. Järvi OH, Lansimies PH. Subclinical elastofibroma in the scapular region in an autopsy series. *Acta Path Microbiol Scand* 1975;83:87-108.
9. Barr JR. Elastofibroma. *Am J Clin Pathol* 1966;45:679-683.
10. Nakamura Y, Okamoto K, Tanimura A, et al. Elastase digestion and biochemical analysis of the elastin from an elastofibroma. *Cancer* 1986;58: 1070-1075.
11. Madri JA, Dise CA, LiVolsi VA, et al. Elastofibroma dorsi: An immunohistochemical study of collagen content. *Human Pathol* 1981;12:186-190.
12. Ross R, Burnstein P. Elastic fibers in the body. *Sci Am* 1971;224:44-52.

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Fine needle aspiration biopsy of thyroid nodules

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Between April 1982 and December 1988, we performed 611 fine needle aspiration (FNA) biopsies in 502 patients with solitary thyroid nodules. The biopsy results were classified as follows: unsatisfactory, 19%; benign, 53%; suspicious, 23%; and malignant, 5%. Malignant lesions were found at surgery in 24 of 25 patients with malignant cytology and 31 of 68 patients with suspicious cytology. Autonomous nodules, obviating the need for surgery, were detected in 5 of 36 (14%) patients with cytology suspicious for follicular neoplasm. We conclude that FNA biopsy of the thyroid nodule is a safe and accurate diagnostic test. Thyroid scintigraphy remains useful in patients with cytologic results suspicious for follicular neoplasm. A cost-effective strategy for managing thyroid nodules is presented. *Wis Med J* 1991; 90(5):285-288.

SOLITARY THYROID nodules affect approximately 4% of the US population, but thyroid cancer is rare.[1-2] The primary aim of thyroid nodule management, therefore, is to identify those patients with malignant nodules, but to avoid operations in patients with benign lesions. Traditional diagnostic approaches using thyroid scintigraphy and ultrasonography lack specificity.[3] Fine needle aspiration (FNA) biopsy of thyroid nodules is now widely used to distinguish benign from malignant lesions.[3] Since 1982, we have safely and effectively used FNA biopsy as our primary method for diagnosing thyroid malignancy. In this paper, we report the results of FNA biopsies performed in 502 patients and suggest a cost-effective strategy for managing thyroid nodules.

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Materials and methods

Between April 1982 and December 1988, we performed 611 FNA biopsies in 502 patients with solitary thyroid nodules. Each patient was evaluated prior to biopsy by a history, physical examination, and frequently by thyroid function tests.

FNA biopsies were obtained with a 25-gauge needle attached to a disposable 10 mL plastic syringe and Cameco^{R} syringe pistol. The aspiration biopsy was performed as an outpatient procedure without anesthesia. Multiple aspirations were taken from each nodule. The material obtained was injected into approximately 40 mL of a 50:50 mixture of 100% ethyl alcohol and normal saline. This was subsequently filtered through an 8 μm polycarbonate screen membrane and stained by the Papanicolaou method.

One pathologist (SMW) interpreted the slides and classified the results as follows: inadequate, benign, suspicious, or malignant.[4] Inadequate specimens could not be interpreted because they contained too few cells. A benign cytology was often diagnostic of a colloid nodule or chronic thyroiditis. Samples were classified as suspicious if they displayed such features as numerous follicular cells with little colloid, predominantly Hürthle (oxyphilic) cells without evidence of chronic thyroiditis, microfollicular or syncytial growth pattern, and cellular atypia. Malignant specimens were those that the cytopathologist was confident of the presence of cancer. In recent years, we have abandoned ultrasonography and recommended thyroid scintigraphy selectively for patients displaying cytopathology suspicious for follicular neoplasm.

Table 1.–Comparison of diagnostic categories with those from the Mayo Clinic.

	Gundersen Clinic		Mayo Clinic	
	No.	%	No.	%
benign	268	53	4013	65
suspicious	116*	23	723+	11
malignant	24	5	221	4
inadequate	94	19	1299	20
total	502	100	6346	100

*Thirty-one percent malignant at surgery.
+Twenty-seven percent malignant at surgery.

Results

We performed FNA biopsies on 435 women and 67 men. Their ages ranged from 15 to 93 years with a mean of 52 years. Table 1 summarizes the diagnostic classification of FNA biopsies and compares the results with those obtained at the Mayo Clinic. In 94 (19%) of patients, the initial biopsy was unsatisfactory. In 24 of these, the lesion was cystic and in others the nodules measured less than 1 cm in size. After one or more repeat biopsies, adequate specimens were obtained in an additional 24 patients. Thus, 429 patients ultimately had biopsies adequate for cytologic interpretation. Twenty-nine patients with inadequate biopsies had surgery. Of these, 26 had benign lesions and three had thyroid cancer (Table 2).

In the 280 patients with benign cytology, 211 had colloid nodules or macrofollicular adenomas and 58 had chronic thyroiditis. Operations were performed in 17 patients with benign cytology. The lesions were benign in 16. The other patient had an atypical adenoma, the center of which contained a 2.5 mm papillary carcinoma. For the remaining patients, we recommended follow-up examination and repeat FNA biopsy in 1 year, or sooner if the nodule was enlarging. Most patients were treated with levothyroxine. Biopsies were repeated routinely in 48 patients and in an additional eight patients because of nodular growth. The repeat biopsies were benign in 41 and suspicious for malignancy in 11 patients. Operations were performed on 15 patients with repeat biopsies. The nodules were malignant in two of 11 patients who were routinely rebiopsied and three of four patients who displayed nodular growth. Cancer was suspected because of the repeat biopsy in all five of the patients with proven malignancies. Thus, of 280 patients with initially benign FNA biopsies, operations were ultimately performed in 32 patients, six of whom had malignant lesions (Table 2).

One hundred and twenty-four patients had cytology suspicious for the following lesions: follicular neoplasms, 65; papillary cancer, 19; Hürthle cell neoplasm, 30; and other lesions, 9. Thyroid scintigraphy revealed autonomous nodules in five of 36 (14%) patients with cytology suspicious for follicular neoplasm. When an autonomous nodule was not demonstrated, we recommended operative removal of the suspicious nodule. Malignancies were found in 31 of 99 (31%) patients.

Surgery was recommended for all patients with malignant cytology. We found cancer in 24 of 25 patients. One patient had previous thyroid irradiation which produced cellular changes that mimicked cancer. Thus, of 64 patients with proven malignancy, 55 had either suspicious or malignant initial FNA biopsy results.

Thyroid ultrasonography was performed early in our series in 21 patients and thyroid scintigraphy in 162 patients. These studies were in general not useful for diagnosing thyroid cancer.

Surgery was performed on 185 (37%) of the 502 patients. Malignancy was found in 64 (35%) of them. Benign surgical specimens included the following: chronic (Hashimoto's) thyroiditis, 15; multinodular goiter, 12; benign adenoma, 29: miscellaneous, 3. The malignant diagnoses were as follows: papillary carcinoma, 44; follicular carcinoma, 5: Hürthle cell carcinoma, 5: lymphomas, 4; medullary carcinoma, 3; anaplastic carcinoma, 2; and metastatic carcinoma, 1.

Except for soreness at the biopsy site, complications from FNA biopsies were not seen.

Table 3 compares the cost and the pattern of clinical management before and after introduction of FNA biopsy at our medical center.

Table 2.–Comparison of FNA biopsy results with surgical pathology findings.*

FNA biopsy findings	No.	No. of operations	Histologic findings *benign*	*malignant*
benign	280	32	26+	6+
suspicious	124	99	68	31
malignant	25	25	1	24
inadequate	73	29	26	3
total	502	185	121	64

*Includes repeat biopsies in patients with inadequate or benign cytology on initial FNA biopsy.
+Fifteen patients had surgery after a repeat FNA biopsy; all five patients with cancer had suspicious cytology after the repeat biopsy.

Discussion

This study indicates that FNA biopsy is a safe and accurate technique for diagnosing thyroid nodules. Some authors have suggested that FNA biopsy be done only in medical centers performing at least 500 biopsies a year.[3] Our results, however, compare favorably to a much larger series,[4] and confirm the good results reported from other institutions performing a moderate number of biopsies.[5-8] We emphasize, however, that an expert cytologist is necessary to obtain accurate results.

Inadequate specimens were initially obtained in 19% of patients; repeat biopsies reduced this to 15%. This frequency of nondiagnostic results is similar to the Mayo Clinic experience.[4] Inadequate specimens

were frequently obtained from cystic or small nodules. Large nodules containing necrotic areas and our conservative approach to cytodiagnosis also contributed to inadequate results. Three cases of malignancy were detected in 29 operations in patients with inadequate FNA biopsy results. Thus, patients with inadequate biopsies should be rebiopsied. If the biopsy is still unsatisfactory, an autonomous nodule demonstrated by thyroid scintigraphy will identify patients not likely to have a malignant tumor (vide infra). Patients with cystic nodules should have the lesion removed in the following circumstances: if the cyst is larger than 4 cm; if the cyst fluid is bloody; if a solid component remains after aspiration of the nodule that cannot be biopsied; and if the cyst fluid repeatedly reaccumulates.[2,9] Patients with an increased risk of cancer, (ie, youth, male sex, cervical lymph node enlargement, rapid growth of the nodule, radiation exposure, or other factors) should have the nodule removed. Patients with inadequate FNA biopsy results who do not undergo surgery should be carefully followed.

Table 3.–Clinical management and diagnostic costs* before and after FNA biopsy.

	Before FNA biopsy 1980-1981			*After FNA biopsy 1982-1988*	
	Cost per procedure (dollars)	**No.(%)**	**Total cost**	**No.(%)**	**Total cost**
patients	—	84	—	502	—
scintigraphy	130	75 (90%)	9,750	162 (32%)	21,060
ultrasonography	143	25 (30%)	3,575	21 (4%)	3,003
FNA biopsy	134	0	—	611 (122%)	81,874
operations	5,500	51 (61%)	280,500	184 (37%)	1,012,000
cancer	—	9 (18%)	—	64 (35%)	—
cost per patient	—	—	3,498	—	2,227

*Estimated from the cost of scintigraphy, ultrasonography, FNA biopsy, and subtotal thyroidectomy requiring three days of hospitalization.

The false negative rate for FNA biopsy varies from 2% to 33%.[10] We found six patients with falsely negative biopsies. One of these patients had a 2.5 mm papillary carcinoma embedded within an atypical adenoma. Suspicious cytology was found in the other five patients on follow-up biopsy. We believe patients with negative cytology on initial FNA biopsy should be followed carefully and the biopsy repeated in one year or sooner if the nodule enlarges. Although the value of levothyroxine therapy for thyroid nodules remains controversial,[11] we often treated patients with negative cytology results with suppressive doses of thyroid hormone.

False positive cytology results are rare.[10] We had only one case, which undoubtedly was due to cytologic changes induced by previous radiation therapy.

Suspicious cytologic reports are a major problem with FNA biopsies. Thirty-one percent of our patients and 27% of the 585 patients with suspicious cytology evaluated at the Mayo Clinic had thyroid malignancy. Cytologic evaluation is especially difficult in distinguishing benign from malignant follicular neoplasms since the diagnosis of malignancy depends on demonstrating vascular or capsular invasion. Routine thyroid echography and scintigraphy were not useful diagnostic tests. These findings were

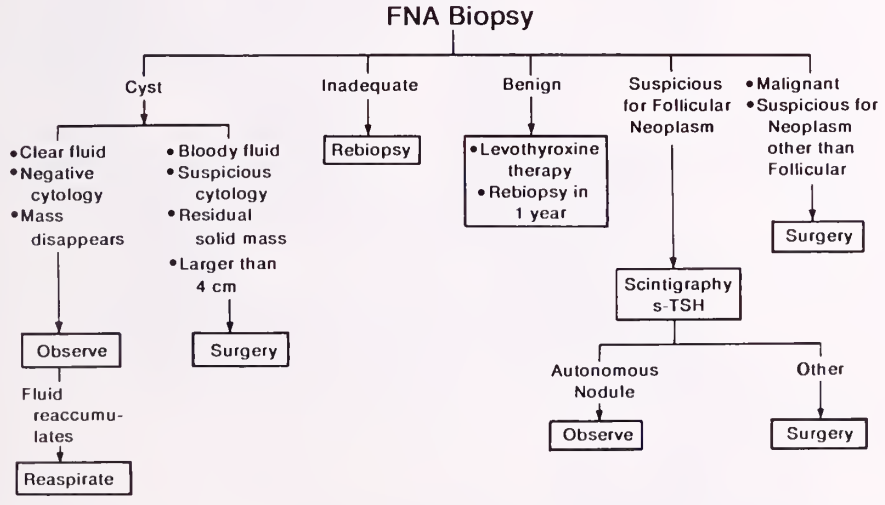

Fig –A cost-effective strategy for the management of thyroid nodules. s-TSH indicates thyrotropin measured by a senstive assay. Surgery should be considered for patients in whom a cyst fluid repeatedly reaccumulates. Patients with benign cytology should be rebiopsied before 1 year if the nodule is enlarging. Patients with autonomous nodules should be treated if they are hyperthyroid.

in agreement with the extensive studies of Van Herle and coworkers.[3,10] Thyroid scintigraphy, however, may be valuable for managing patients with cytology suspicious for follicular neoplasm. Autonomous thyroid nodules secrete thyroid hormones independent of pituitary gland control. As the amount of thyroid hormone secretion increases, serum thyrotropin (TSH) levels fall and the normal thyroid tissue takes up progressively less iodine. The thyroid scan demonstrates progressively greater activity in the nodule until finally all of the activity resides in the autonomous nodule producing the so-called hot nodule. Detection of low concentration of TSH, made possible with the development of sensitive assay methods, supports the diagnosis of an autonomous nodule.[12] Since autonomous nodules are rarely malignant,[13] the demonstration of this finding in five of 36 patients with cytology suspicious for follicular neoplasm made surgery unnecessary for these patients.[3] Our study is retrospective and not all of our colleagues have fully adhered to our diagnostic protocol. Nonetheless, since introducing FNA biopsy at our institution, the cost of managing patients with thyroid nodules has been reduced by about $1300 per patient (Table 3). Echography is rarely performed and the routine use of thyroid scintigraphy substantially decreased. More importantly, the frequency of thyroid surgery has been reduced from 61% to 33%. Despite this notable decrease in the frequency of thyroid surgery, the yield of carcinoma in operated patients has increased from 18% to 39%.

In summary, the FNA biopsy is a safe and accurate technique for the diagnosis of thyroid nodules. We suggest that physicians who have access to a qualified cytologist, either in their own institution or by consultation, use FNA biopsy as their initial diagnostic test. The strategy outlined in the figure is a cost-effective approach for managing thyroid nodules.

Acknowledgements

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References

1. Griffin JE. Southwestern Internal Medical Conference: Management of thyroid nodules. *Am J Med Sci.* 1988;296:336-347.
2. Mazzaferri EL, de los Santos ET, Rofagha-Keyhani S. Solitary thyroid nodule: Diagnosis and management. *Med Clin N Am.* 1988; 72:1177-1211.
3. Van Herle AJ. The thyroid nodule. *Ann Int Med.* 1982;96:221-232.
4. Goellner JR, Gharib H, Grant GS, et al. Fine-needle aspiration cytology of the thyroid, 1980 to 1986. *Acta Cytol.* 1987;31:587-590.
5. Asp AA, Georgitis W, Waldron EJ, et al. Fine-needle aspiration of the thyroid: Use in an average health care facility. *Am J Med.* 1987;83:489-493.
6. Pepper GM, Zwickler D, Rosen Y. Fine-needle aspiration biopsy of the thyroid nodule: Results of a start-up project in a general teaching hospital setting. *Arch Int Med.* 1989;149:594-596.
7. Dwarakanathan AA, Ryan WG, Staren ED, et al. Fine-needle aspiration biopsy of the thyroid: Diagnostic accuracy when performing a moderate number of such procedures. *Arch Int Med.* 1989;149:2007-2009.
8. Findling JW, Shaker JL, Larson PR. Thyroid needle aspiration in a community hospital. *Wis Med J.* 1989;88:19-22.
9. de los Santos ET, Keyhani-Rofagha S, Cunningham JJ, et al. Cystic thyroid nodules: A dilemma of malignant lesions. *Arch Int Med.* 1990;150:1422-1427.
10. Ashcraft MW, Van Herle AJ. Management of thyroid nodules II: Scanning techniques, thyroid suppression therapy, and fine-needle aspiration. *Head and neck surgery.* 1981;3:297-321.
11. Morita T, Tamai H, Oshima A, et al. Changes in serum thyroid hormone, thyrotropin and thyroglobulin concentrations during thyroxine therapy in patients with solitary thyroid nodules. *J Clin Endocrinol Metab.* 1989;69:227-230.
12. Földes J, Bános CS, Csillag P, et al. Examination of serum thyrotropic hormone level by "suprasensitive" immunoradiometric assay in functioning thyroid adenoma. *Acta Med Hung.* 1987;44:329-1047.
13. Hamburger JL. The autonomously functioning thyroid nodule: Goetsch's Disease. *Endo Rev.* 1987;8:439-447. ❑

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The survey interviews were conducted by telephone interview from the Gallup Houston office during middle to late January 1991. With a sample of 400, the confidence level is ±4.9% at the .95 test level.

Grading the doctor

Physicians as individuals have a much stronger public image than the profession as a whole (Fig 1). When

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asked about their personal physicians, large majorities said the doctor explains things well (88%) and spend enough time with patients (77%). Most respondents reject the notions that their physician is too interested in money (83%) and acts superior to other people (90%). Wisconsin residents are *not* losing faith in their own doctors (88%).

Eighty percent of Wisconsin respondents said they had a personal physician. Younger, male, less wealthy and minority respondents are less likely to have a personal physician than the average respondent.

When asked to rate their satisfaction with their last visit to the doctor, 94% in Wisconsin and 92% in the nation said they were satisfied overall (Fig 2). Wisconsin respondents were most impressed by the doctor's staff (96%), by the medical care they received (92%) and by the way the doctor explained things (90%). On a national scale, the figures were 94%, 92%, and 89%, respectively.

Less positive was the wait to get an appointment (Wis 83%; US 82%) and the wait to see the doctor (Wis 78%; US 79%). The fee charged was the least satisfactory part (Wis 71%; US 75%) of the visit.

In Wisconsin, 71% of the respondents have visited the doctor within the last year. Older, more affluent, and females are more likely to have visited their doctor within the last 6 months. Males make up the bulk of the respondents who have not visited their doctors in over a year.

Grading the profession

Gallup asked a series of questions to gauge the public's perception of the medical profession and, although the perception of physicians as a group is not a favorable one, it is better in Wisconsin than it is nationally.

People losing faith in doctors. The statement receiving the highest mark (65%) was that "People are beginning

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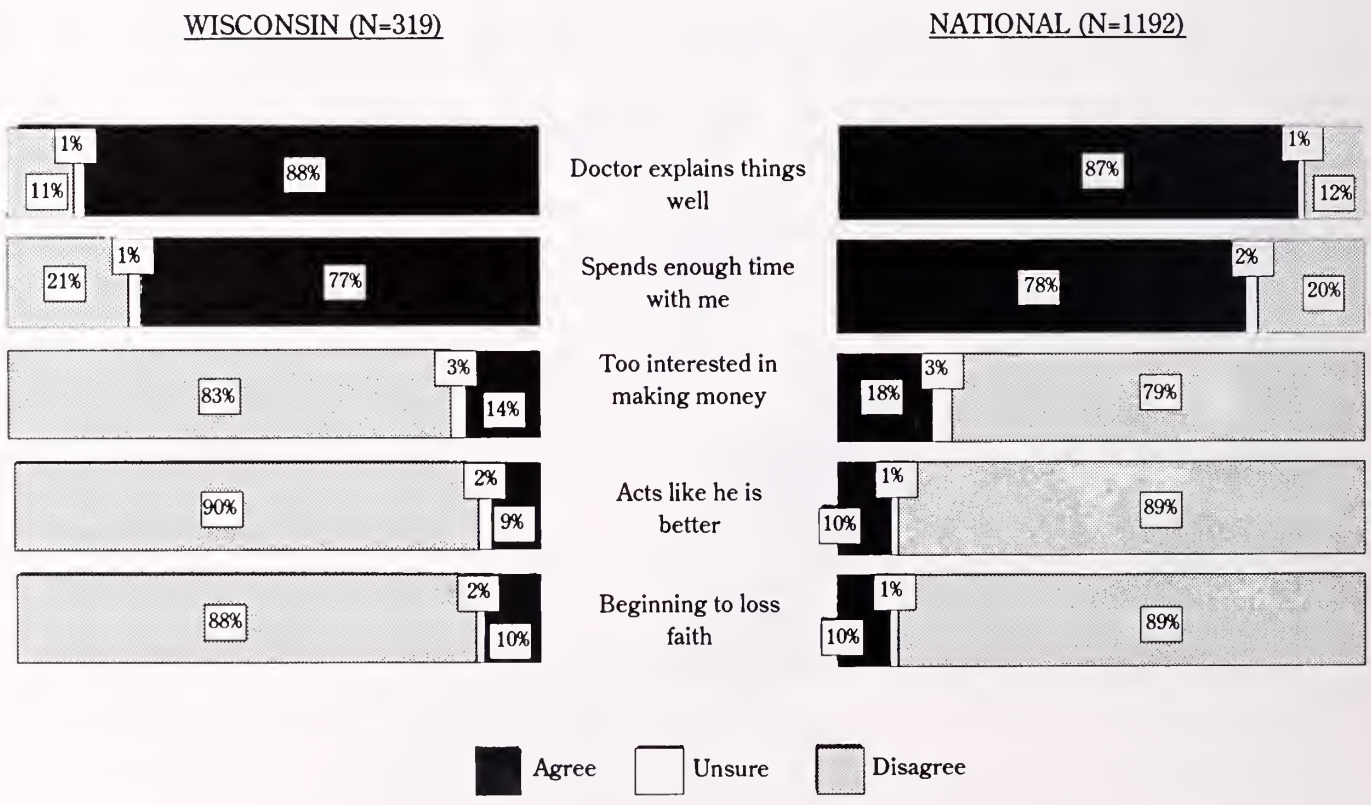

Fig 1.–Evaluating the personal physician: Wisconsin and the United States.

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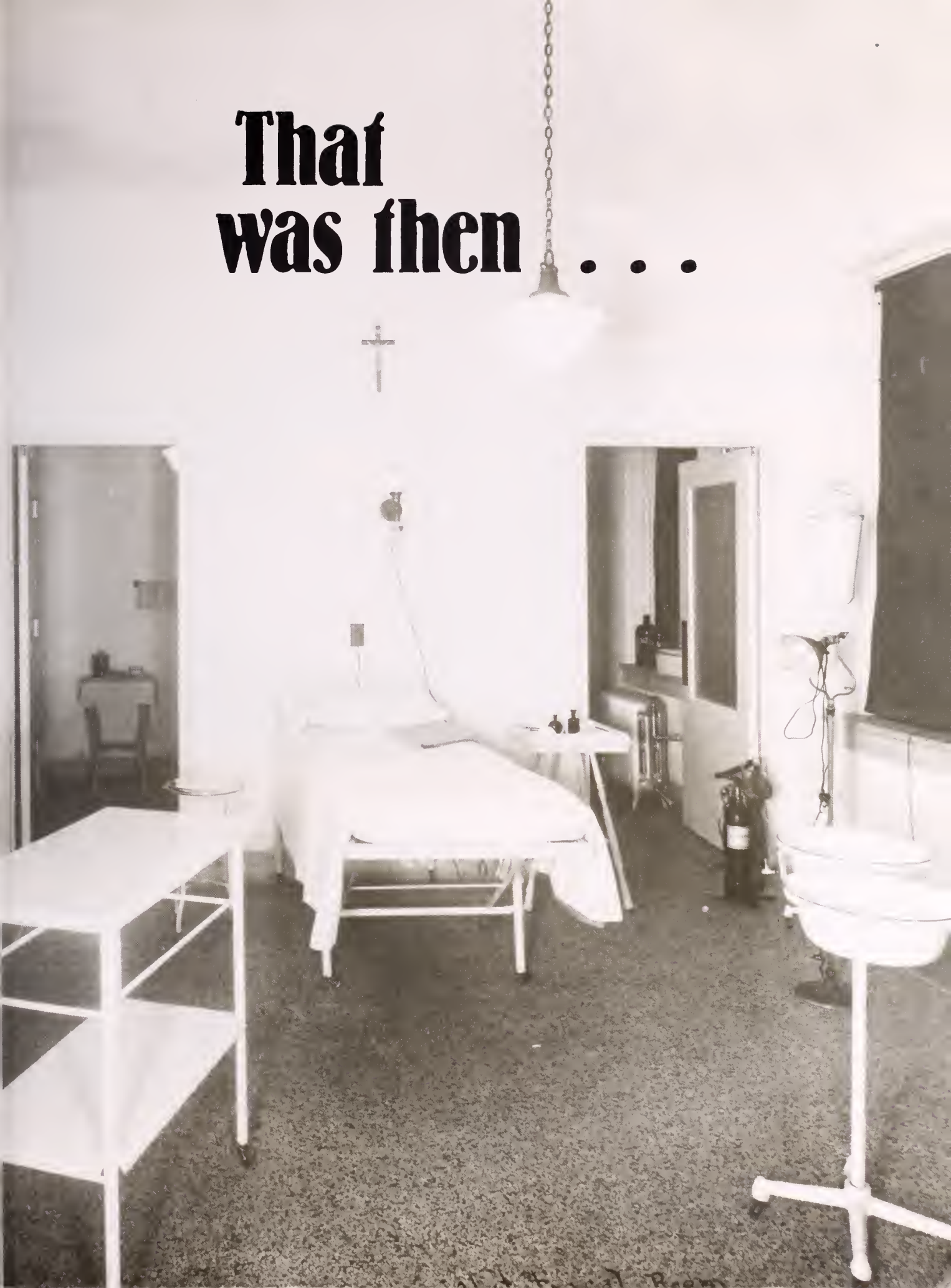

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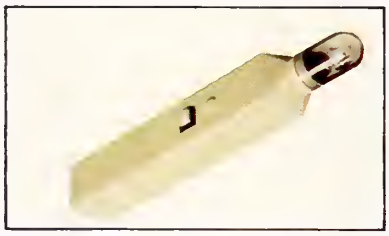

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to lose faith in doctors." Nationally, 69% agreed with this statement. The younger, less educated, lower economic level, minority and female respondents all give significantly higher than average "agreement" scores.

Doctors too interested in money. A majority (52%) of respondents also perceives doctors as too interested in making money; nationally, that perception is held by 63%.

Doctors explain things well. A Wisconsin plurality (47%) of the respondents agree with this statement, as compared to 42% nationally. The demographics are rather even across most subgroups for this statement. One exception is females, who are much less happy than males with the way doctors explain things.

Elderly able to get care. Only 42% of Wisconsin's respondents say they think that the elderly are able to get the care they need. Nationally, that percentage falls to 34%. In Wisconsin, this disagreement was especially prevalent among middle-aged, middle-income respondents.

Doctors act like they are better. Wisconsin doctors appear to be more humble than their peers across the country: 59% of Wisconsin's respondents disagreed that doctors act like they are better than others, compared to 55% nationally.

Most doctors spend enough time. Sixty percent in Wisconsin and 63% across the country disagreed with this statement. These data suggest that the public perceives this aspect of a doctor's behavior as seriously lacking. Disagreement comes mainly from male respondents with higher incomes.

Poor are able to get care. The public does not believe that the poor are able to get the care they need, either in Wisconsin (29% agreed) or in the United States as a whole (25%).

Diagnosing the health care system

The poll asked an open-ended question about what the respondents perceived as the main problem facing health care and medicine in the United States today. The cost of health care was the issue Wisconsin resi-

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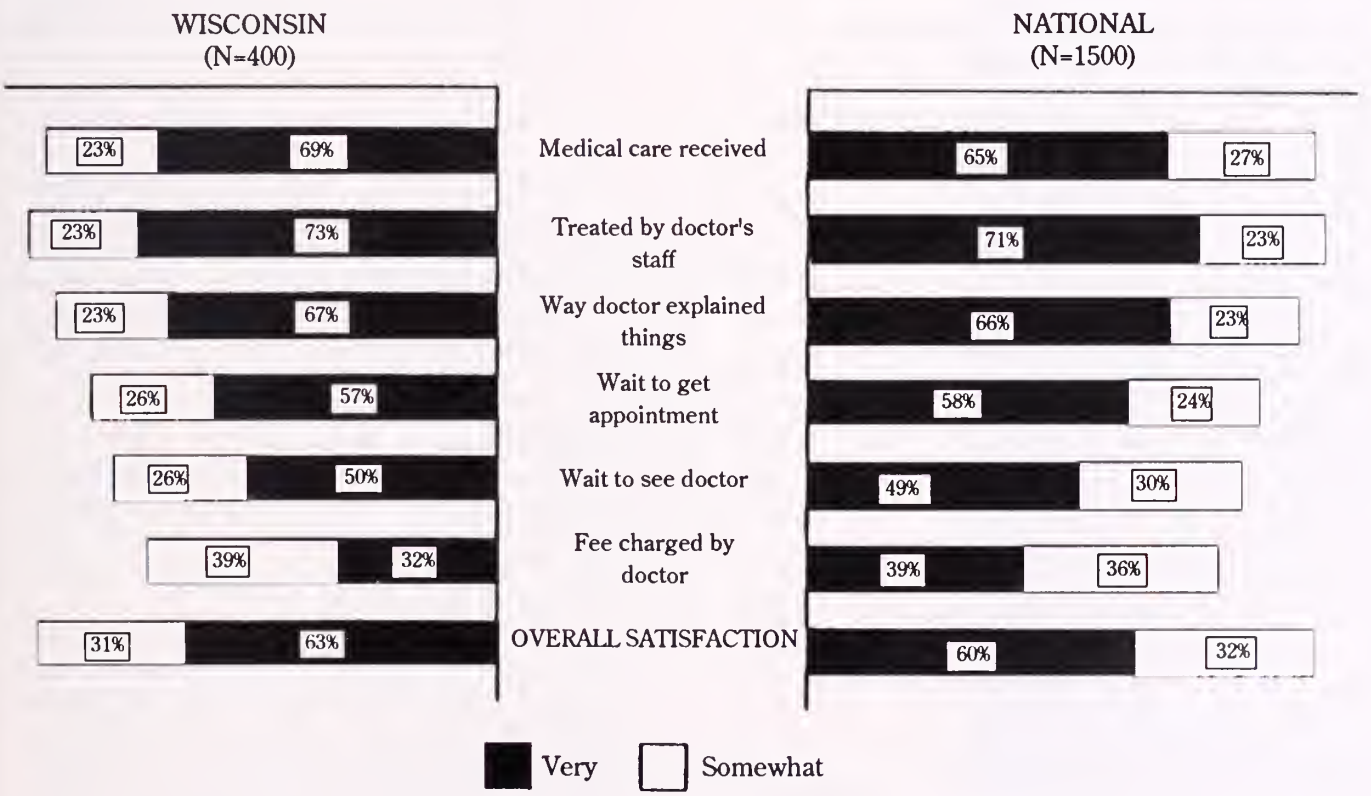

Fig 2.–Degree of satisfaction with the most recent visit to the doctor's office: Wisconsin and the United States.

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dents cited most often. High insurance costs also received notable mention.

Wisconsin residents are somewhat more confident than the nation as a whole in their ability to pay for usual health care and to cover the costs of a major illness, and two thirds said that the out-of-pocket costs of care affected their decisions to seek medical treatment (Fig 3). One in five respondents said they had delayed seeking health care during the past year because of cost, and more than 50% of those said their condition was serious.

Concern about health care costs is highest among the middle-aged, increases directly with education and income, and is higher among white than among minority populations. Younger and older respondents, lower economic level respondents, less educated respondents and blacks all are significantly less confident that they could pay. Most demographic groups have very little confidence that they could pay for long-term care. Younger, less educated, lower economic level, and female respondents were most likely to delay treatment.

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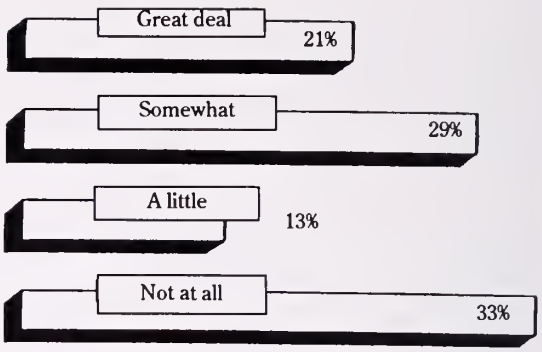

Fig 3.–The degree to which out-of-pocket costs affect decisions to seek medical treatment.

Professional liability

According to 80% of Wisconsin residents, physicians are paying too much for malpractice insurance; according to 81% awards for "pain and suffering" in malpractice cases should be limited (Fig 4).

Wisconsin respondents were asked to evaluate three possible methods of handling alleged malpractice cases:

- sue the physician in court;
- provide a specified amount of money for particular injuries or poor outcomes of treatment, as is done in Worker's Compensation, without disputing whether or not the physician was negligent; and
- instead of going to court, have an impartial person or group resolve the dispute, as in binding arbitration.

The concept of an arbitration mechanism was evaluated most favorably (68% rating it "excellent" or "good"), with lawsuits and a compensation system receiving equal ratings of favorability (43%) from the survey respondents. The respondents appear to favor some method other than lawsuits, but are leery of a method that does not assess negligence.

Quality of care

A majority (51%) in both Wisconsin and the United States rate the quality of American health care higher than the care offered in other industrialized nations; only 17% rate American health care as inferior to the care in other nations (Fig 5).

In Wisconsin, younger, rural respondents are most likely to perceive American health care as better than that of other industrialized nations. Urban respondents, especially in Milwaukee, are more likely to be critical of American health care.

Half of the Wisconsin respondents said that cost containment measures are undermining the quality of care (Fig 6). Younger, lower economic level, and less

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educated respondents are more likely to perceive that the quality health care has suffered.

Availability of care

The significant number of Wisconsin respondents (12%) said they are not within reasonable reach of medical services.

Less educated, lower income, and minority respondents have greater difficulty gaining access to medical services.

Wisconsin respondents were asked to evaluate four possible methods the state could use to make health care more affordable and available:

- Change insurance laws to allow basic health care plans to be sold to small employers and limit the rates insurers can charge for these policies.
- Require all employers to provide health care coverage to their employees.
- Have all health care provided and paid for through a single system regulated by the state government.
- Increase state spending for health services provided free or at low cost to persons without health insurance.

Requiring employers to provide health care insurance leads the list of possible reforms with 76% of Wisconsin respondents giving the idea an "excellent" or "good" rating (Fig 7). Wisconsin respondents also said that limiting rates and selling basic health care plans to small employers is a very good idea. A majority of state respondents (65%) also approve of increas-

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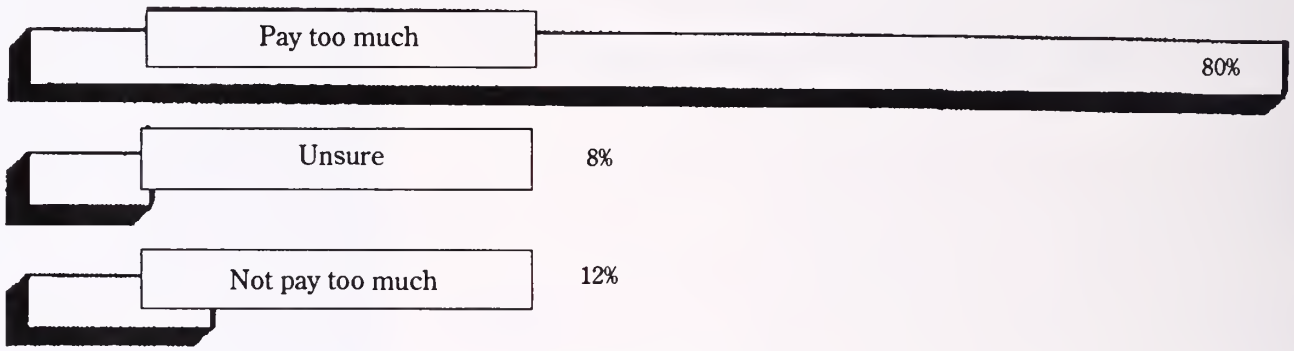
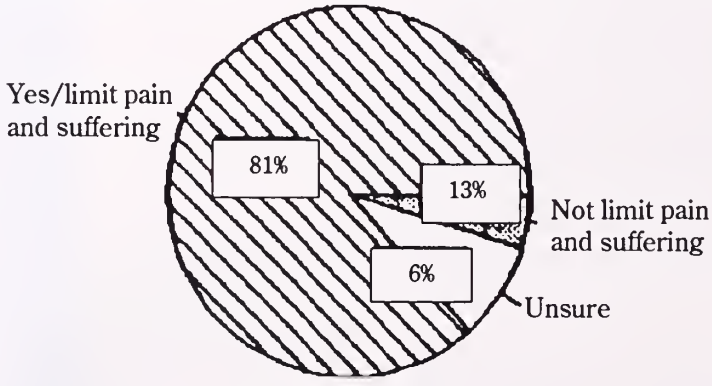
Do you agree or disagree with the following statement? "Doctors have to pay too much for malpractice insurance."



COST TO DOCTOR
(N=400)

Do you think there should be a limit on the amount of money that can be awarded to someone for their "pain and suffering," such as loss of companionship, when suing a doctor for malpractice?



LIMITS ON PAIN
AND SUFFERING AWARDS
(N=400)

Fig 4.–Public perceptions of the liability insurance crisis in Wisconsin.

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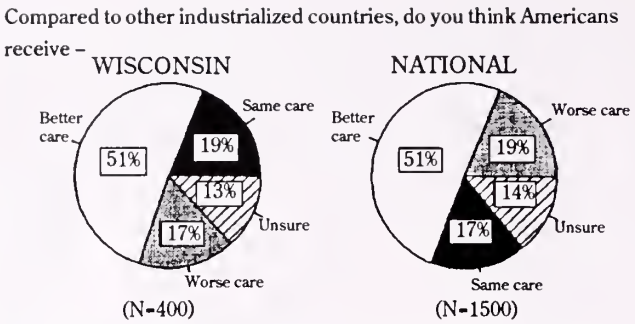

Fig 5.–Comparing American health care to that of other industrialized nations: Wisconsin and United States.

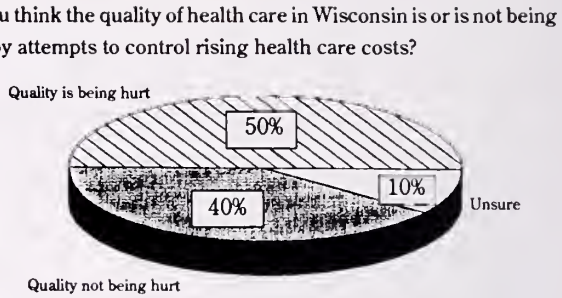

Fig 6.–The perceived effects of cost containment measures on the quality of health care in Wisconsin.

Continued from page 296

ing state spending on health care services for those who are uninsured. Half give "excellent" or "good" ratings to the concept of having all health care paid for and provided through a comprehensive state system.

Medicare and Medicaid

A strong majority (67%) of Wisconsin respondents said that the elderly should pay a percentage of their own health care costs, based on their income; nationally, 60% agreed (Fig 8). The elderly are most likely to disagree with this concept, while younger, middle-aged, educated and male respondents are most likely to agree.

Wisconsin and US respondents' support for Medicare payments on long-term health care is high (78% and 75%, respectively), but is especially so among the younger and lower economic level categories. The elderly are not significantly higher than average in

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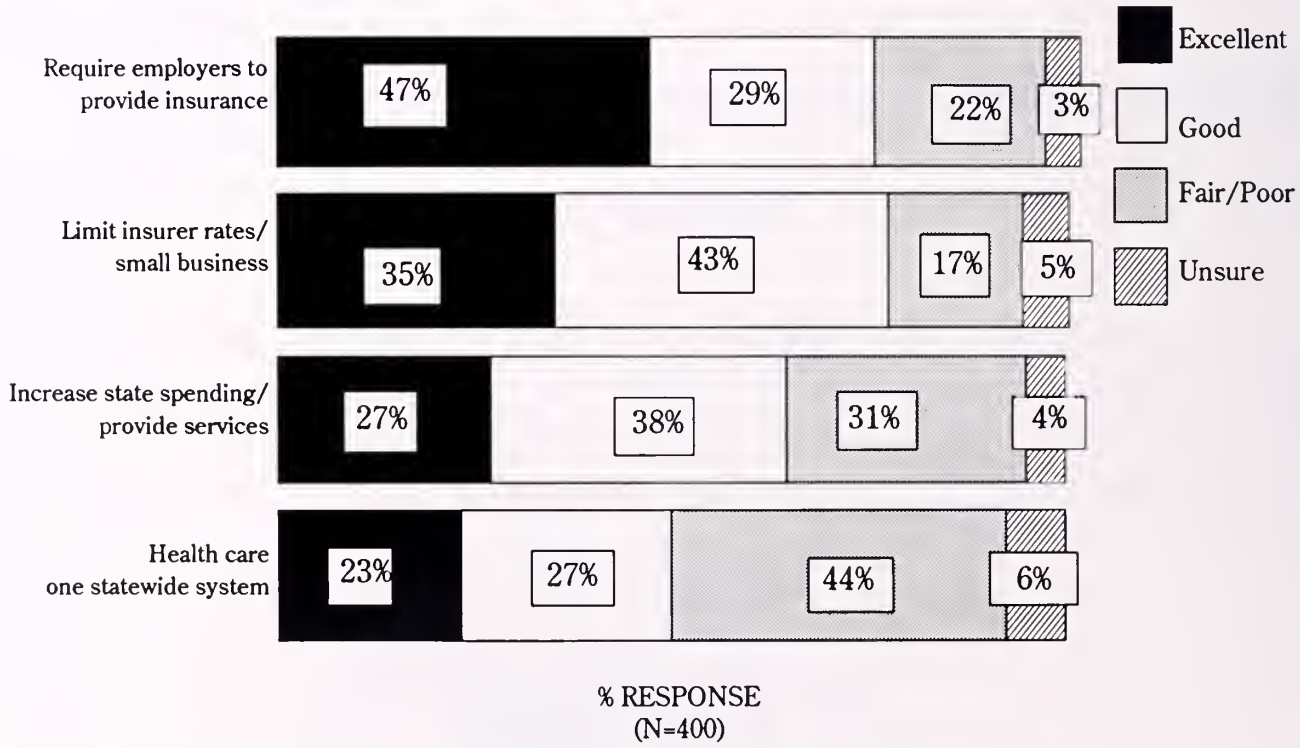

Fig 7.–Degree of support for four methods of making health care more available.

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Danny Thomas, Founder

Continued from page 298

support of the long-term nursing Medicare payment concept.

More than a third of the respondents (35%) said that too few people are covered by Medicaid in Wisconsin; 30% said the number of people currently covered is the "right" number; and 12% said that too many people are covered. Twenty-three percent were unsure.

Federal spending

The Wisconsin respondents overwhelmingly support (71%; 69% nationally) increased federal spending to provide better access to health care (Fig 9). Although socioeconomic status makes a significant difference in the degree to which government spending is supported, a majority of every major socioeconomic group approved an increase in government spending.

Figure 10 shows that both Wisconsin and national respondents (69%) support increased federal spending on health care, even with an assured tax increase.

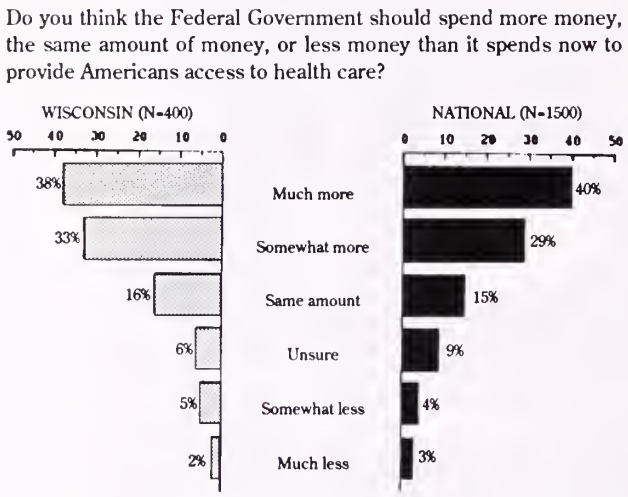

Fig 9.–Degree of support for increased federal spending to increase access to health care: Wisconsin and the United States.

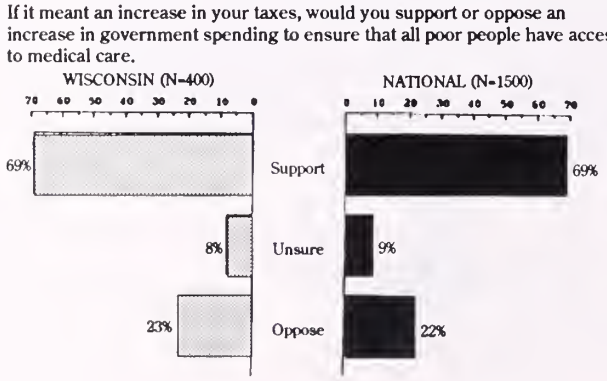

Fig 10.–The effects of increased taxes on public support for greater federal funding on helath care services for the poor: Wisconsin and the United States.

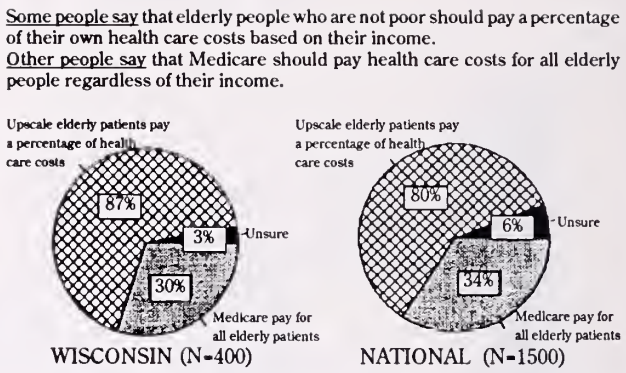

Fig 8.–Degree of support for requiring Medicare recipients with higher incomes to pay a percentage of their health care costs: Wisconsin and the United States

Medical care choices

The current and future trends in medicine suggest that Wisconsin citizens will be faced with a series of difficult choices. Figure 11 shows how Wisconsin respondents differ from national respondents on choices regarding government involvement in medicine, availability of medical technology, immediacy of health care, and having a personal physician.

Government involvement. A majority (Wis 52%; US 55%) of both respondent groups would rather pay private doctors and hospitals than paying higher taxes and having the government be in charge of medical health care delivery.

Availability of technology. A majority (Wis 56%; US 57%) of respondents in both groups prefer to pay more for health care if the latest technology can be available in their community. Significant minorities, however, (Wis 41%; US 39%) would prefer to pay less and have the latest medical technology available on a regional basis.

Health care immediacy. The survey data show strong support for higher payments and immediate health care service (Wis 79%; US 80%).

Personal physician. As with immediacy, survey respondents would rather pay more for health care and have their own personal physicians, rather than pay less and be assigned a physician. This preference is stronger in Wisconsin (84%) than it is nationally (79%). The data tables show that older, female upper economic level and white respondents are significantly more likely to want personal physicians.

Who should set health care policies?

The Gallup poll found consumer organizations score highest for credibility (79% saying they trust them a

Continued on page 302

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Continued from page 298
"great deal" or "some"). Organizations of hospitals rate second (78%), and organizations of doctors are third (72%). The remaining field of players in the health care arena ranked: business organizations (65%), labor unions (60%), public officials (55%), and health insurance companies (53%).

Summary

1. *Evaluation of personal physician.* Wisconsin respondents give their personal physicians very high ratings. Two areas of special importance are explaining things well (88%) and spending enough time with the patient (77%).
2. *Office visit.* The survey data indicated a very satisfied (94%) patient population when considering their last office visit.
3. *Malpractice.* Respondents in Wisconsin are convinced their doctors pay too much for malpractice insurance (80%). An equal number (81%) would limit pain and suffering awards.
4. *Personal physician.* A strong majority of respondents (84%) would rather pay higher rates for health care in order to be able to choose a personal physician than pay lower rates and be assigned a physician.
5. *Health care availability.* Wisconsin respondents strongly support (76%) requiring employers to provide health care insurance for workers. Survey respondents also strongly support passing laws that would make health insurance plans available to small business (78%).
6. *Health care comparisons.* By a bare majority (51%), Wisconsin respondents feel they receive better health care than people in other industrialized nations of the world.
7. *Federal spending on access to health care.* A majority (69%) of Wisconsin respondents support increased federal government spending on the delivery of health care, even if that means higher taxes.
8. *Ability to pay.* More than half of Wisconsin respondents (52%) feel confident they can pay for routine medical costs. This confidence drops significantly when they consider a major illness (38%) or long-term care (15%).
9. *Long-term care.* More than three out of every four Wisconsin respondents (78%) feel that Medicare should pay for long-term nursing care, even if it means an increased tax burden.
10. *Government involvement in medicine.* A majority of respondents (52%) would rather pay higher health care costs to private doctors and hospitals, than have the government control of medicine.

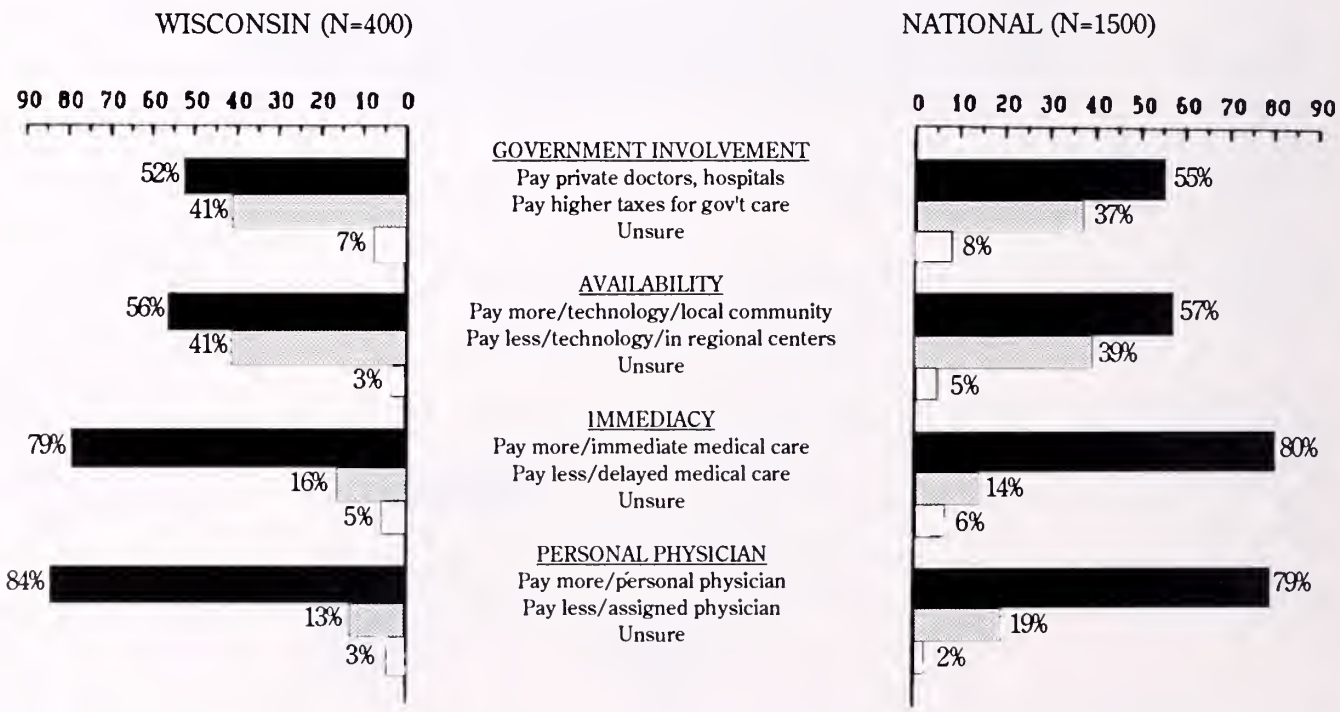
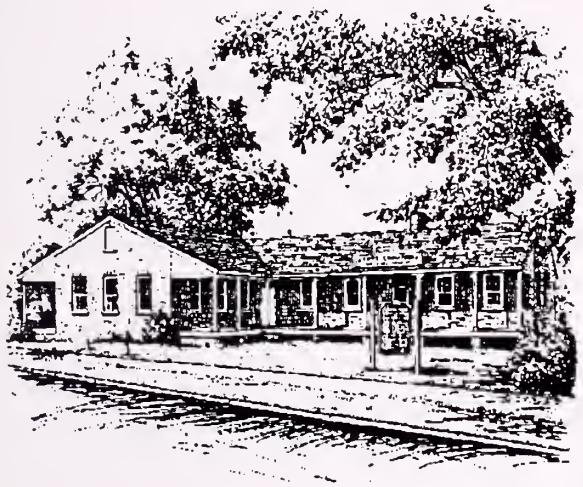


Fig 11.–Making the tough health care choices: Wisconsin and the United States.

11. *Availability of technology.* A majority of survey respondents (56%) would rather pay higher health care costs to have the latest medical technology located within their community than pay less for health care and have the latest technology located in regional centers.
12. *Immediacy of care.* A strong majority (79%) of the respondents would rather pay higher health care costs and have immediate care available than pay lower costs and have care delayed.
13. *Health insurance coverage.* Ninety-one percent of Wisconsin respondents has some form of health insurance plan.
14. *Medicare payments.* A strong majority (67%) of the Wisconsin respondents feel that elderly patients with higher incomes should pay a percentage of their health care costs.
15. *Delayed treatment.* One in five survey respondents (20%) said they had delayed medical treatment over the past year due to cost considerations.
16. *Quality of health care hurt by cost containment.* Half of Wisconsin respondents said that the quality of health care in Wisconsin has suffered due to cost containment efforts.
17. *Trust in organizations proposing health care policies.* The survey data indicate that Wisconsin respondents place their trust in consumer organizations first (79%), followed by hospital organizations (78%), and organizations of doctors (72%).
18. *Image.* The overall image of the medical profession in Wisconsin has problems. Sixty-five percent of the public say they are losing faith in doctors, and a majority (52%) of respondents say doctors are too interested in making money.
19. *Costs.* The Wisconsin survey respondents are mainly concerned about the cost of modern medicine, including high insurance costs. These concerns overshadow all other major factors. ❑



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- Subject matter must fall within the parameters of scientific medicine: clinical, case report, research and review
- Paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- Limited to 10 pages, typewritten, double-spaced, 1-inch margins
- Illustrations are encouraged, but must be included in the 10-page length limit
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority in all decisions

Criteria:

- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *Applicability:* usefulness of results to private practitioner, academician, researcher
- *Content:* depth of analysis, continuity of discussion supporting the main thesis, feasibility of conclusions
- *Innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, advancement of basic understanding
- *Organization*
- *Clarity of writing*

Deadline:

Entries must be received by the *Wisconsin Medical Journal* no later than February 14, 1992: PO Box 1109, Madison, WI 53701

Public health

Malignant melanoma: trends in Wisconsin, 1980-1989

Rebecca L. Byers, MD; Paula M. Lantz, MA; Patrick L. Remington, MD; and Jerri Linn Phillips, MS, Madison

THE INCIDENCE OF MALIGNANT melanoma has risen rapidly worldwide during this century, doubling every decade since 1930. Nationally, the incidence of melanoma is increasing at a rate of 3% to 4% per year, faster than any other cancer in humans.[1] This once rare disease now accounts for 3% of all cancers in the US and is becoming one of the more common malignancies in young adults. Mortality rates from melanoma are closely linked to the stage of disease at time of diagnosis, as there is no effective treatment for metastatic disease. In this report, we assess recent trends in melanoma incidence and mortality in Wisconsin.

Approximately 300 cases of malignant melanoma are diagnosed each year in Wisconsin. The age-adjusted incidence rate is greater among men compared with women (Fig 1). Although the incidence rates have not changed among men or women over the past 10 years, there has been a trend toward earlier diagnosis (Fig 2). Among men, the percent of cases diagnosed in situ increased from about 2% in 1980 to about 8% in 1989, whereas among women, the percent increased from 2% to 15%. This increase has been associated with only slight declines in the percentage of non-localized cases.

The mortality rate for males is consistently higher than the rate for females and shows a steady increase over the past 10 years ($p < 0.01$). In contrast, the mortality rate for females has remained relatively stable (Fig3).

Comment

The death rate due to malignant melanoma appears to be increasing among men but not among women in Wisconsin. This trend is consistent with national cancer data, which show a 24% increase in melanoma mortality for US males from 1980 to 1987, compared with no increase for females during the same period.[2] It may be that the trend toward earlier diagnosis among women has resulted in improved survival among women diagnosed with malignant melanoma.

In contrast to national data, the Wisconsin data do not show an increase in the incidence of malignant melanoma for either men or women. It is possible that the actual number of melanoma cases has been underestimated by the Cancer Reporting System. This population-based tumor registry ascertains cases of melanoma from death certificates, hospital reports, and clinics, when those clinics are maintained with the rest of the hospital record. Karagas et al[3] identified out-patient treatment as the reason for a 21% underestimation of melanoma in Washington state in 1984.

Prevention of melanoma is aimed at avoiding excessive sun exposure, either by limiting exposure time or by using sunscreens and protective clothing when exposed to sunlight.

Continued on page 307

Dr Byers is a Fellow in General Internal Medicine at the University of Wisconsin Hospital and Clinic. Lantz is a senior research specialist with the Center for Health Policy and Program Evaluation, UW-Madison. Dr Remington is a medical epidemiologist with the Section of Environmental and Chronic Disease Epidemiology, Division of Health. Phillips is the lead analyst for the Wisconsin Cancer Reporting System, Center for Health Statistics, Division of Health. Part of this work was made possible by a grant from the National Cancer Institute (R01-CA-46883). Address reprint requests to: Patrick Remington, MD, Wisconsin Division of Health, 1 W Wilson St, PO Box 309, Madison, WI 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin.

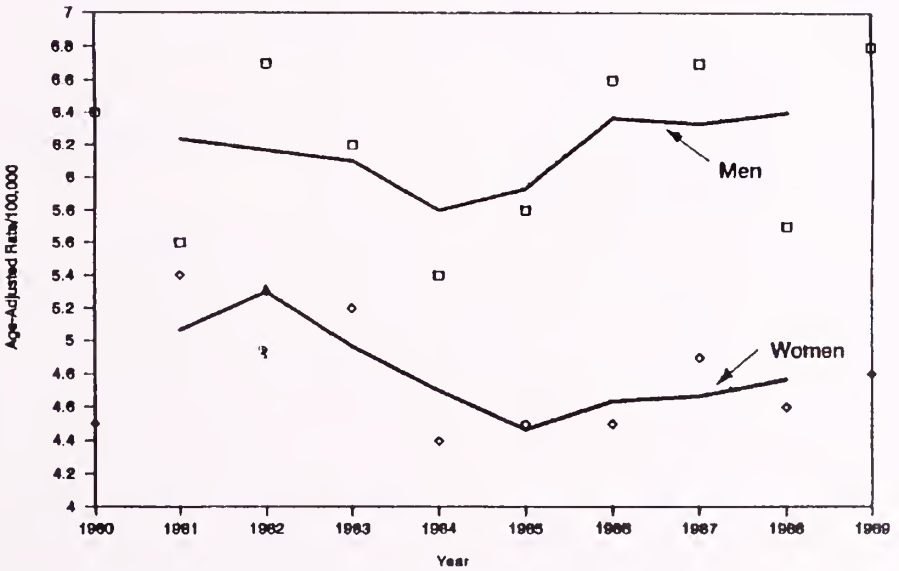
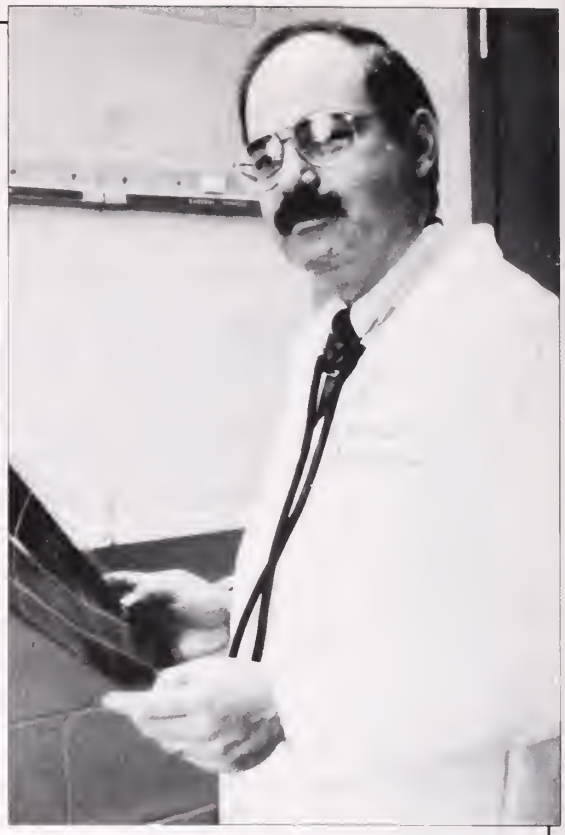


Fig 1.–Trends in melanoma incidence for men and women, Wisconsin, 1980-1989. The solid line is the 3-year moving average.



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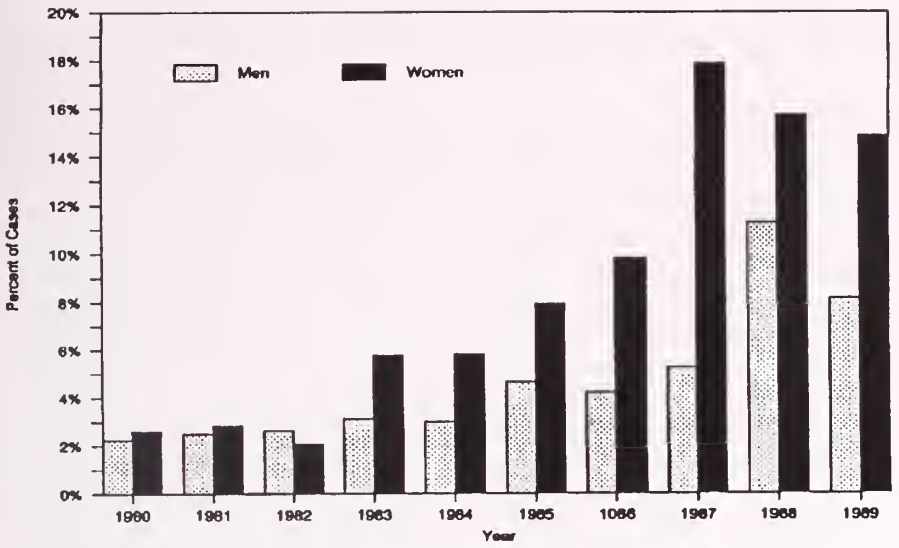

Fig 2.–Trends in the percent of melanoma cases diagnosed in situ for men and women in Wisconsin, 1980-1989.

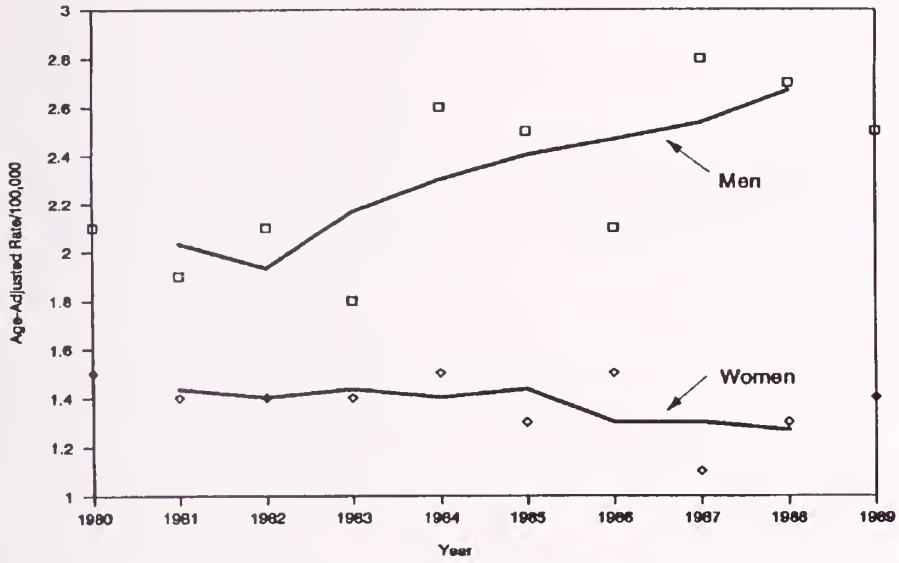

Fig 3.–Trends in melanoma mortality for men and women in Wisconsin, 1980-1989. The solid line is the 3-year moving average.

These precautions may be especially important in the young, and specifically in those with the tendency to sunburn. In recent years, benign melanocytic nevi (moles) have been shown repeatedly to be the major risk factor for developing melanoma.[4] In addition, there is strong cumulative evidence suggesting that sunlight promotes the development of nevi, especially in children.

The US Preventive Services Task Force[5] recommends routine screening by complete skin examination for persons with a family or personal history of skin cancer, clinical evidence of precursor lesions (eg, dysplastic nevi, certain congenital nevi), and those with increased occupational or recreational exposure to sunlight. This group believes that the optimal frequency of such examinations has not been determined and should be left to clinical discretion. The American Cancer Society[6] and the National Cancer Institute[7] are somewhat more aggressive in recommending a complete skin examination as part of the periodic health examination.

The data presented in this report suggest a trend toward earlier diagnosis of malignant melanoma in this state, especially among women. This change could be the result of improved screening by health care providers and by earlier self-detection by patients during the 1980s. Both possibilities suggest a greater awareness of the disease and emphasize the importance of early diagnosis.

References

1. Silverberg E, Boring CC, and Squires TS. *Cancer statistics.* 1990;40:9-26.
2. Gloeckler LA, Hankey BF, Edwards BK. *Cancer Statistics Review,* 1973-1987. Bethesda: National Cancer Institute, 1990.
3. Karagas MR, Thomas DB, Roth GH, et al. The effects of changes in health care delivery on the reported incidence of cutaneous melanoma in western Washington state. *Am J Epidemiol.* 1991;133:58-62.
4. Green A, Swerdlow AJ. Epidemiology of melanocytic nevi. *Epidem Reviews.* 1989;11:204-221.
5. *US Preventive Services Task Force: Guide to clinical preventive services.* Baltimore: Williams and Wilken; 1989.
6. American Cancer Society. *Guidelines for the cancer-related check-up: Recommendations and rationale.* New York: American Cancer Society; 1980.
7. National Cancer Institute. *Working guidelines for early cancer detection: Rationale and supporting evidence to decrease mortality.* Bethesda: National Cancer Institute; 1987. ❑

Series coordinators

The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, are coordinating this series for the *Wisconsin Medical Journal.*

Individuals pay top share of national medical bills

A RECENT STUDY by the Department of Health and Human Services (DHHS) documents a shift in health care cost burdens it was reported in the April 12, 1991, *Wall Street Journal*. According to the report, private business paid 28.8% of the nation's $520 billion health care expenditures in 1988, up from 17% in 1965, but down slightly from 29.2% in 1987. The drop marked the first decline in businesses share of health costs since 1985. But even so, businesses health care tab was higher than ever before at $149.9 billion. Individuals spent $194.2 billion in 1988, 37.4% of the total. That's more than their 36.9% share in 1987, but far less than the 60.6% in 1965.

Much of the health care spending from employers and individuals goes toward insurance. Employees' contributions to health insurance premiums amounted to 8.1% of the nation's health expenditures in 1988 ($42.1 billion), compared with 5.8% in 1980 and 10.8% in 1965. Private employers' share of private health insurance premiums, meanwhile, came to 21.2% of health care costs in 1988 ($110.5 billion), 21.5% in 1980 and 14.3% in 1965.

The federal government paid 16.6% of health care expenditures in 1988, up from 9% in 1965, the year Medicare was founded, but a slightly smaller share than in the early 1980s when the government paid more than 17% of the total. Still the government's bill in dollars soared to $86.2 billion in 1988 from $42.6 billion in 1980 and $3.4 billion in 1965. State and local governments, meanwhile, put out $75.1 billion for health care in 1988, 14.4% of the total, about the portion it contributed through most of the 1980s. In 1965, states and municipalities paid 11.7% of the total.❑

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The AMA proposal to improve access to affordable, quality health care.

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Simply put, *Health Access America* proposes health insurance coverage for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America's physicians are leading the way to reforming the health care system by speaking out on these critical issues. To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association
on behalf of member physicians and their patients.

A message from The American Medical Association for the Health Access America Proposal

Medicare bonus

WPS-Medicare paid $36,000 in bonus payments to 121 Wisconsin physicians practicing in Health Manpower Shortage Area (HMSA) in the first quarter of 1991. Physicians practicing in the HMSA areas outlined in the February 1991 *Communique* are eligible for a 10% bonus on Medicare payments.

For more information, contact Trish Ramsay of the SMS staff at 1-800-362-9080 or (608) 257-6781.❑

Banker's Life supplemental Medicare insurance policy

THE SMS HAS RECEIVED several calls from physicians regarding Banker's Life supplemental Medicare insurance policy interpretations. Certain insurance agents have contacted physicians' offices and stated that the physician had overcharged specific Medicare patients.

The agent normally cites the "physician reform act," which refers to the new limiting charge law that limits non-participating physicians Medicare charges to 125% (140% for evaluation and management services) of the Medicare non-participating prevailing charge. See the Dec 5, 1991, Medigram for further information.

Banker's Life has implemented a computer edit which flags claims when the charge is more than 125% (140%) of the Medicare approved amount. Banker's Life, however, has not identified the legitimate exceptions to this law. For example, technical components of diagnostic tests, approved charges based on the customary, 50th percentile charge, or services for which no prevailing has been established are exempt from the 125% (140%) limit.

If your office is contacted by a Banker's Life agent and you are unable to convince them of the appropriateness of your charge, please feel free to refer the agent to Trish Ramsay of the SMS staff at 1-800-362-9080 or (608) 257-6781.❑

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American Heart Association

Kohl and Kasten ask HCFA to postpone CLIA certification fees

In recent letters to Health Care Financing Administration (HCFA) Administrator Gail Wilensky, Sen Herb Kohl (D) and Sen Robert Kasten (R) requested that HCFA postpone plans to impose clinical laboratory provisional certification fees before final CLIA regulations are in effect. Kohl and Kasten drafted the letters in response to a request from SMS Secretary-General Manager Thomas L. Adams, CAE.

HCFA plans to impose a provisional certification fee of $261 on physicians and laboratory facilities prior to finalization of the rules to implement the Clinical Laboratory Improvement Amendments of 1988.

"I do not feel that it would be fair to ask physicians and laboratory facilities to pay provisional certification fees to comply with regulations that are not even finalized or enforceable," wrote Kohl. "I am also concerned that imposing this fee will cause more physicians to consider discontinuing laboratory services currently offered to patients, which could seriously erode access to care in rural parts of our country.

Kasten also shares concerns about the imposition of fees on physicians and laboratories. He and Kohl have asked HCFA to consider reissuing the revised regulations as a new proposed rule, with another public comment period prior to finalization.

"Given the complexity and sweeping effect of these regulations, as well as the unprecedented number of comments on last year's proposed rules, allowing another comment period on revised proposed rules could help to ensure that the final rules are as responsive as possible to the legitimate concerns of physicians and other health care professionals," wrote Kohl.❑

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Wisconsin high court will decide right to die case

The Wisconsin Supreme Court decided in April to retain jurisdiction of *In the Matter of the Guardianship of L.W.*, Wisconsin's first opportunity to resolve the issue of whether a guardian may authorize termination of life-sustaining nutrition and hydration of an incompetent patient without an advance directive such as a power of attorney for health care authorizing this decision.

As reported in the Feb 27, 1991, *Medigram*, the patient known as "L.W." died Feb 3, 1991, after remaining in a persistent vegetative state since May 31, 1989. Both parties to the Wisconsin Supreme Court appeal petitioned the Court to continue the appeal since the decision to do so was discretionary.

The Wisconsin Supreme Court will next hear oral arguments on the matter "in due course."❑

Wisconsin physician named to HCFA advisory committee

SEVEN PRACTICING PHYSICIANS, including three nominated by the AMA, have been named to the Advisory Committee on Medicare-Physician Relationships. One of the three physicians nominated by the AMA include Wisconsin physician Susan L. Turney, MD, an internist from Marshfield. The committee will chaired by Nancy Gary, MD, senior medical advisor to the HCFA administrator.

The committee will advise the HCFA administrator on the existing Medicare policies and procedures that directly relate to physicians' provision of services to Medicare beneficiaries as well as on Peer Review Organization and carrier policies and procedures.

The Advisory Committee looks at methods to improve Medicare carrier services, responsiveness to physicians, and the cost and administrative burden the Medicare program places on physicians. It does not consider payment issues.❑

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

April 1991

*Andres, Jerome C., Mosinee
*Bixby, Mark R., Grantsburg
Black, David P., Milwaukee
*Brauer, Warren A., Sheboygan
Cesarec, Robert G., New Berlin
*Chaillet, James R., Milwaukee
Chang, Chen-Kang, Madison
*Cody, Edward F., Beaver Dam
*Erickson, Daniel R., Horicon
*Francisco, Orlando M., Tomahawk
*Heggestad, Kay A., Madison
*Kim, Zaezeung, Racine
*Knier, Michael S., Oshkosh
*Kochar, Mahendr S., Milwaukee
*Kuhr, Gregory J., Milwaukee
*Kuritz, Robert R., Madison
Larson, Harry H., Ashland
*Lyerla, Eric R., Milton
*Melvin, John L., Milwaukee
*Oujiri, John C., Ashland
*Patton, Charles H., Racine
*Pechman, Kenneth J., Racine
*Reinhard, Harold J., Green Bay
*Saarinen, David M., Ashland
*Schulgit, Ronald E., Racine
*Schulz, Emil, Eau Claire
*Stanley, Jerrel L., Menomonee Falls
*Thompson, Teddy L., La Crosse
*Van Pernis, Paul, Ashland
*Whaley, Ralph C., Barron ❑

Physician briefs

The * indicates a member of the SMS.

David Smith, MD, of Plymouth, recently joined the Plymouth Clinic Family Medical Center. A family practitioner, Dr Smith graduated from the University of Illinois Medical School at Springfield, and completed his residency at Rockford.

Robert A. Nogler, MD, of Bruce, recently joined the Marshfield Clinic Ladysmith Center. A family practitioner, Dr Nogler earned his medical degree from the University of Loma Linda in California, and completed his residency in family practice at Reading Hospital in Reading, Penn.

Mark A. Hughes, MD,* of Lancaster, recently joined Family Practice Associates of Iowa County. A family practitioner, Dr Hughes earned his undergraduate degree in science at the University of Northern Iowa. He earned his medical degree from the University of Osteopathic Medicine and Health Sciences in Des Moines. He served his residency at Des Moines General Hospital. Family Practice Associates is affiliated with the Dean Medical Center of Madison.

Jane D. Kivlin, MD, of Elm Grove, has been appointed associate professor of ophthalmology and pediatrics at the Medical College of Wisconsin. Dr Kivlin is a pediatric ophthalmologist who specializes in genetic-related eye disorders, eye diseases in premature infants and strabismus.

Thomas J. Tackman, MD,* of Milwaukee, will join the Ft Atkinson Memorial Hospital this summer. He will be rotating to the new clinic in Whitewater. An internist, Dr Tackman graduated from the Medical College of Wisconsin. He is currently completing his residency at the Medical College of Wisconsin.

William E. Walker, Jr, MD, of Mequon, has been appointed assistant clinical professor of family medicine at the Medical College of Wisconsin. A Medical College of Wisconsin alumnus, Dr Walker will work with third-year students in the ambulatory care course.

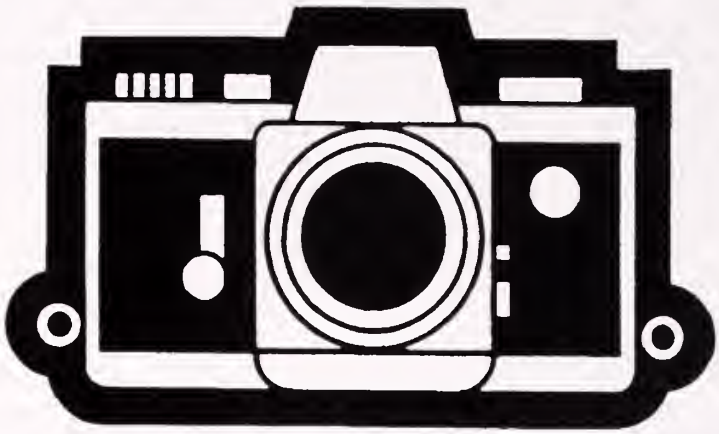
Manucher J. Javid, MD,* of Madison, was elected president of the International Intradiscal Therapy Society at its annual meeting held in Houston in April 1991. Dr Javid is chair of the Department of Neurological Surgery at the University of Wisconsin-Madison.

Richard A. Reinhart, MD

Richard A. Reinhart, MD,* of Marshfield, was recently elected chair of the Board of Trustees, Marshfield Clinic Division of Research and Education. A member of the *Wisconsin Medical Journal* editorial board, Dr Reinhart is a cardiologist. He earned his medical degree from Ohio State University College of Medicine in Columbus. Dr Reinhart completed an internship and served his residency at Duke University Medical Center in Durham, North Carolina. Other new officers elected include

Continued on page 313

WMJ physician photo contest



Awards: Publication on the cover of the *Wisconsin Medical Journal* and a commemorative plaque, presented at the SMS annual meeting.

Eligibility: The competition is open to members of the State Medical Society of Wisconsin and its Auxiliary only.

Guidelines: A total of three entries in any combination of the following categories may be submitted.

- A doctor's life
- The science of medicine
- The art of healing
- Wisconsin wildlife
- Wisconsin places
- Wisconsin people

Entry in the contest constitutes agreement to allow the entered photographs to be published in or on the cover of the *Wisconsin Medical Journal*. Vertical photos are preferred, but horizontal photos are accepted. Entrants retain all other rights to their photographs.

Entries must be original prints or slides in color or black and white. Prints may be mounted, but not framed, and mount size should not exceed 11x14. Negatives must be available for all prints.

The back of each photograph must bear the photographer's name, address and phone number, and the title—if any—of the photo. Enclose, preferably on a separate sheet, a brief description of where, when and how the photo was taken. If possible, note the make and model of camera and lens used for each photo, film used, exposure settings, and any special equipment. Previously published material may be entered; however, please include the information on when and where the photo has appeared.

The *WMJ* cannot be responsible for entries—so do not send your only copy.

Deadline: All entries must be postmarked no later than February 14, 1992. Send entries to: Photo Contest, *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

Continued from page 311

Douglas J. Reding, MD,* vice chair; and Patrick J. Juneau, attorney for the clinic.

Charles A. Errico, MD,* of Green Bay, recently joined the medical staff of Two Rivers Community Hospital. and eye surgeon, Dr Errico received his medical degree from the Medical College of Wisconsin. He served his internship at Ohio State and completed a residency at the University of Rochester in New York.

Paul E. Hankwitz, MD, of Milwaukee, received the Outstanding Physician Award from the Academy of Home Care Physicians on May 9 during the group's annual meeting in Chicago. An internist, Dr Hankwitz, in addition to working as associate medical director of the Nortwestern Mutual Life Insurance Co, devotes much of his time to promoting the concept of team home care. A graduate of the Medical College of Wisconsin, Dr Hankwitz specializes in geriatrics and gerontology.

Paul E. Hankwitz, MD

Gerald E. Osband, MD

Gerald E. Osband, MD,* of Wausau, has joined the Wausau Insurance Companies as a vice president in the company's employee benefits business center. Dr Osband holds a bachelor's degree in bacteriology from the University of California-Los Angeles, and a medical degree from the Univeristy of California-San Francisco. He completed his residency in family medicine at the University of Minnesota and is currently a family physician with Family Health Specialists of Wausau.❑

Obituaries

Saul Kenneth Pollack, MD, of Milwaukee, died Feb 19, 1991, in Milwaukee. Dr Pollack was born Oct 24, 1904, in Milwaukee, and graduated from Rush Medical College. His internship and residency were completed at Milwaukee County Hospital. Dr Pollack was one of the first three psychiatrists to be certified in Wisconsin and one of the first two psychoanalysts to practice in Milwaukee. He had been a member of the medical staff at Mountain Sinai Hospital, a consulting neuropsychiatrist at the old Johnston Emergency Hospital and also a member of the staffs at Columbia, St Joseph's and Deaconess hospitals. He also served as chairman of the department of psychiatry at the Sinai-Samaritan Medical Center. He was a member of the American Psychiatric Association, the Milwaukee County Medical Society, the SMS, and the AMA. Surviving are a daughter, Rosemary Wild, of Severna Park, Md; and a son, John R., of Edina, Minn.

Malcolm M. Hipke, MD, 89, of Milwaukee died Mar 9, 1991, in Milwaukee. Dr Hipke was born March 21, 1901, in Milwaukee. He graduated from the University of Michigan Medical School and served an internship at Harper Hospital in Detroit. His residency was completed at New York Lying-In Hospital and a fellowship was taken at the University of Vienna. Dr Hipke served in the US Navy from 1942 to 1946. He practiced medicine in Port Washington in the 1930s and then in the Milwaukee area until he retired. He also had served as a clinical instructor at Milwaukee County Hospital. Dr Hipke was elected a founding fellow of the American College of OB/GYN in 1952. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving is his widow, Ardys, of Milwaukee.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.□

Frank P. Furlano, MD, 36, of La Crosse, died March 11, 1991, in Iron Mountain, Mich. Dr Furlano was born Jan 17, 1955, in La Crosse, and graduated from the Medical College of Wisconsin, in Milwaukee. His internship and residency were completed at the Gundersen Medical Foundation/Lutheran Hospital-La Crosse. In 1986, Dr Furlano joined the medical staff of the Gundersen Clinic. He recently was board-certified by the American Society of Addiction and was to become medical director of all in-patient chemical dependency programs at Lutheran Hospital. He had been medical director of the medical center's Chemical and Alcohol Detoxification program since 1987. In 1990, Dr Furlano had been appointed to the SMS Committee on Alcoholism and Other Drug Abuse. He was a member of the La Crosse County Medical Society, the SMS, and the AMA. Surviving are his widow, Lori; two daughters, Sarah and Rebecca; and two foster daughters, Bridget and Amanda.

John T. Siebert, MD, 60, of Baraboo, died March 11, 1991, in Baraboo. Dr Siebert was born on Apr 22, 1920, in Washington, Penn, and graduated from the University of Wisconsin Medical School-Madison. His internship was completed at the Medical College of Virginia in Richmond. He served in the US Army from 1956 to 1958 and stationed in San Antonio and El Paso, Tex. Dr Siebert returned to Baraboo in 1958 and was practicing medicine at the time of his death. In 1963, he was named Baraboo's outstanding man of the year. He was a director of the Wisconsin Association of Medical Directors of Nursing Homes, past chief-of-staff of the St Clare Hospital in Baraboo, the medical director of Jefferson Meadows Care Center, and also was a fellow of the American Academy of Family Physicians. He was a member of the Sauk County Medical Society, the SMS, and the AMA. Surviving are his widow, Suzanne; two daughters, Susan Mitchell, of Boston, and Jeanne Pena, of Miami Shores; and one son, John W., of New York.

Miklos Szilagyi, MD, 82, Milwaukee, died March 18, 1991, in Milwaukee. Dr Szilagyi was born Feb 21, 1909, in Hungary, and graduated from Loyola University Stritch School of Medicine, in Maywood, Ill. His internship and residency were completed at Mercy Hospital, in Chicago. Dr Szilagyi had practiced in the Milwaukee area for 50 years. Surviving are four daughters; Rose Marie Lusk, of Mequon; Mary Ann Giuntoli, of

Milwaukee; Elizabeth and Rose Sziliagyi, of Lakeland, Fla; and one son, Miklos Jr, of Lansing, Mich.

George Herbert Lawrence, MD, 72, formerly of Stevens Point, died April 6, 1991, in Mesa, Ariz. Dr Lawrence was born March 17, 1919, in Stevens Point, and graduated from Marquette University School of Medicine. His internship was served at Great Lakes Naval Hospital, and his residency was completed at the University of Minnesota. He served in the US Navy from 1943 to 1947. He practiced medicine for many years in St Louis, Mo. Surviving are his widow, Hope, two daughters, Jean, of Washington, DC, and Linda Santesteban, of Phoenix; and two sons, Dr George W., of Modesto, Calif, and Jonathan B., of Kirkwood, Mo.

William J. Swift, MD, 75, former Kenosha physician, died March 24, 1991, in Kenosha. He was born May 4, 1915, in Chicago, and graduated from Loyola University School of Medicine. His internship was served at the US Naval Hospital, in Oakland, Calif, and his residency was completed at St Francis Hospital in Evanston, Ill. Dr Swift served in the US Navy from 1942 to 1946. He was on the medical staff of Kenosha Hospital and Medical Center. Dr Swift was director of radiology at Kenosha Hospital from 1950 to 1981, and had served as president of the medical staff in 1975. He was a member of the Kenosha County Medical Society, the SMS, and the AMA. Surviving are his widow, Lyn; two sons, Dr William, of Madison, and Christopher, of Baltimore; and a daughter, Maria, of Madison.

Barbara Ann Brew, MD, 62, Madison, died April 12, 1991, in Madison. Dr Brew was born July 21, 1928, in Batavia, New York, and graduated from the Woman's Medical College of Pennsylvania in Philadelphia. She completed her internship and residency at Charity Hospital of Louisiana in New Orleans. Dr Brew was a faculty member in the Department of OB/GYN at LSU, and later became an assistant professor of OB/GYN at Emory University in Atlanta. She is credited with helping to establish the cervical cancer detection programs at LSU and Emory University. In 1960, Dr Brew came to Madison and was a clinical professor affiliated with the University of Wisconsin Medical School and also has been in medical practice for the past thirteen years at the Jackson Clinic. She was a member and fellow of the American College of OB/GYN, American Cytology Association, The Wisconsin Society of OB/GYN, the Dane County Medical Society, the SMS, and the AMA. Surviving is a son, Paul Allen Waters, of Lake St Louis, Missouri. ❑

Join Dr. McGee.

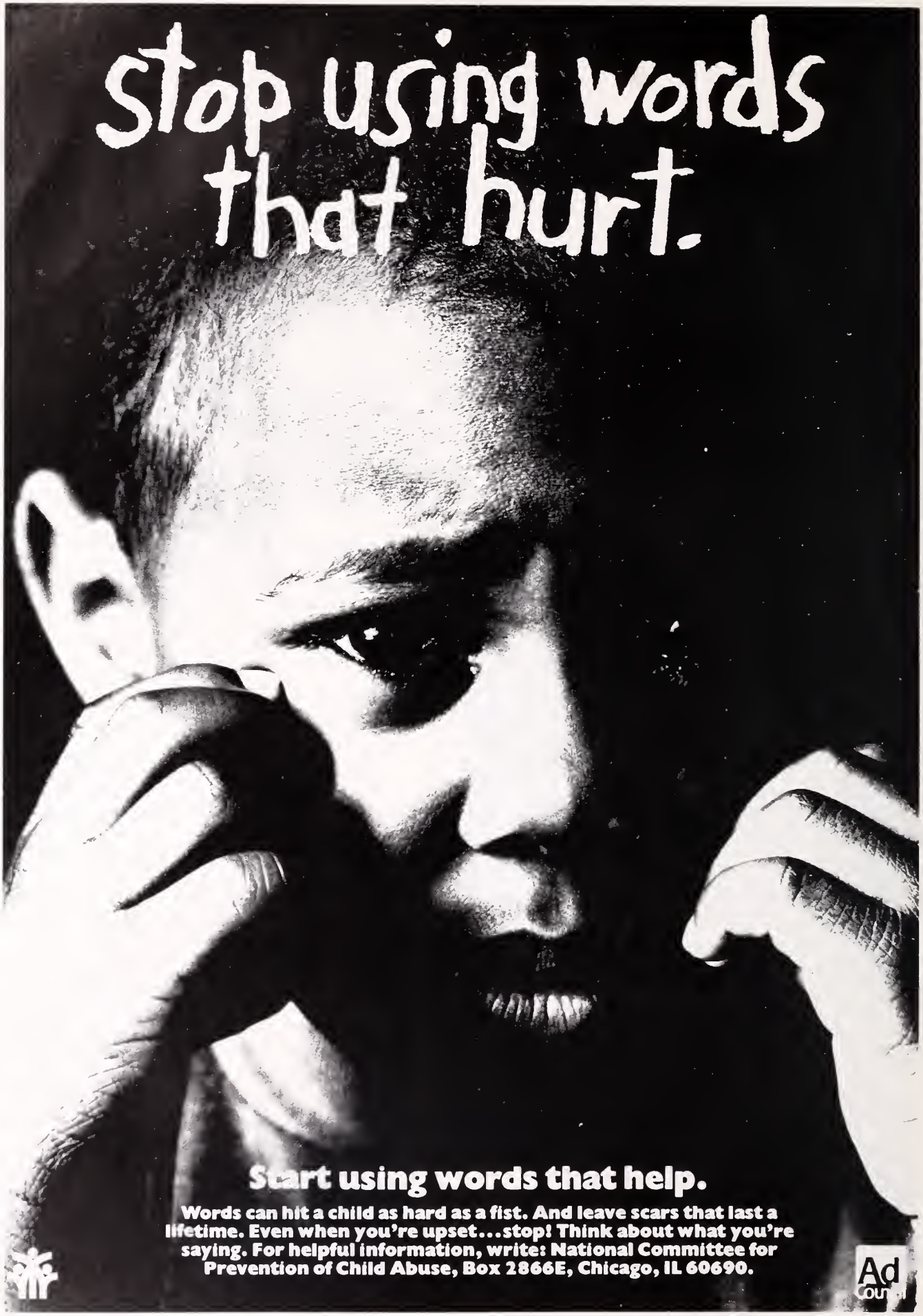
"Without the AMA, many, many public issues would not even be addressed. For example, every physician should be proud of the very strong, courageous stand the AMA has taken on the issue of AIDS. And it's important to remember, AMA policy is not made by an exclusive few but by people who are in the trenches every day fighting disease. The AMA is the voice of physicians, it's the one body in medicine today that represents the collective interests and opinions of doctors in this country."

Join Dr. George McGee, Gastroenterologist, in the AMA. Call this toll-free number now.

Join The AMA.

1-800-AMA-3211

American Medical Association



Wisconsin Committee for Prevention of Child Abuse, 1045 E. Dayton St., Rm. 202D, Madison, WI 53703. (608) 256-3374.

Wisconsin family practitioner and internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to: Stuart Lancer, MD, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 6-9/91

Family practice. A prime family practice awaits you in sunny, metropolitan Phoenix, Arizona. We have additional FP opportunities in picturesque Wisconsin and Illinois. Available benefits include student loan repayment, CME allowance, relocation expense assistance and more. For confidential inquiry, call 1-800-969-7715. Dan Jones, Gielow/Laske Associates, Inc, 306 North Milwaukee St, Milwaukee, WI 53202. 6/91

Door County, Wisconsin. One to two BC/BE internists to join hospital-based physicians' clinic. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Gerald M. Worrick, Administrator, 330 South 16th Place, Sturgeon Bay, WI 54235. p6-8/91

Seventeen-physician multi-specialty group needs FP, IM, OB/GYN and Peds. Located on the edge of the Ozarks only one hour from St Louis. Excellent community to raise a family. Excellent school systems and a service area of 200,000 residents. Excellent benefits. Contact Ronald Stevens, Administrator, Medical Arts Clinic, 301 West Liberty St, Farmington, MO 63640; ph 314-756-6751. 6-8/91

RATES: 55 cents per word, with a minimum charge of $25 per ad.

BOXED AD RATES: $30 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg*, copy for the August issue is due July 1.

SEND TO: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Emergency department physician, Wisconsin (Stoughton). Emergency department staff physician Stoughton Hospital expanding to two full-time ED positions supplemented by contract service. 7,000 visits/year ED located in community of 9,000, fifteen miles southeast of Madison metropolitan area. Other responsibilities include departmental administrative activities and employee health. Prefer physicians that are board-prepared or board-certified in emergency medicine or family practice. Competitive compensation package including full benefits as hospital employee and malpractice insurance. Contact Steven J. Novacheck, MD, Medical Director of Emergency Services, 900 Ridge St, Stoughton, WI 53589; ph 608-873-2264. 6/91

Internal Medicine. A prime internal medicine practice awaits you in sunny, metropolitan Phoenix, Arizona. We have additional IM opportunities in picturesque Wisconsin and Ohio. Competitive income guarantee. Available benefits include malpractice insurance, CME allowance, relocation expenses assistance, administrative/financial support and more. For confidential inquiry, call 1-800-969-7715. Dan Jones, Gielow/Laske Associates, 306 North Milwaukee St, Milwaukee, WI 53202. 6/91

Wausau, Wisconsin. Diagnostic radiologist for hospital based practice. Guaranteed income, excellent benefits. Send CV to V D Luthra, MD, Radiology Associates of Wausau, 2800 Westhill Dr, Wausau, WI 54401. p6/91

Seeking radiologist to share a part-time practice in the Milwaukee area. X-ray, ultrasound, CT, mammography. No nights. No call. No Saturdays or Sundays. Contact radiology at 414-463-2202. p6/91

Wisconsin. Two young BC internists are seeking a third BC/BE internist for well-established, rapidly growing practice located in pleasant central Wisconsin University town of 30,000. Ideal practice opportunity with equal balance of consultative and primary care; well equipped 120-bed hospital, 12-bed ICU. Comprehensive benefit package includes first year salary guarantee, full malpractice insurance and partnership buy-in after one year. Send CV to: Stevens Point Internal Medicine, SC, 3504 E Maria Dr, Stevens Point, WI 54481. p6-9/91

Exceptional opportunity for family practice physician to join established staff of in-house medical clinic for major corporation in the Milwaukee metropolitan area. Opportunity available immediately. Please send vitae to Dept 632 in care of the Journal. 6/91

Family physician. Located on 45 minutes from Minneapolis/St Paul, the residents of Baldwin are proud of their community for good reason. It boasts progressive businesses, a healthy retail district, accredited educational programs, and unlimited recreational activities! One additional family physician is needed to join this well-established practice; currently, a physician's assistant and four family physicians provide care for this community. Contact: Loriese A. Stoll, Ramsey Clinic, 640 Jackson St, St Paul, MN 55101; ph collect 612-221-3067. 3-4/91;6/91

Family practice Minnesota. Physician needed for broad based practice in exceptional rural community. Shared call, fully equipped and staffed office, outstanding hospital, excellent guaranteed compensation, full benefits, and bonus. **Family practice Wisconsin.** Multi-specialty group of 16 physicians seeks BE/BC physician for partnership. Less than one hour from metro area. For this and other opportunities in the upper midwest, send CV to Mary Jo Cordes, MDsearch, PO Box 21507, St Paul, MN 55121 or call 612-454-7291. 6-9/91

Urgent care. Marshfield Clinic is seeking physicians trained and certified in primary care (family practice, internal medicine, pediatrics or emergency medicine) to join newly developing urgent care practice in Marshfield, Wisconsin. Specialists representing all branches of medicine and surgery provide support care and services. A full-time physician will work 45 to 50 hours per week, usually four 12 hour days, including periodic week-ends and holidays. Opportunities exist to combine this practice with an ER practice if desired. Marshfield was recently designated by American Demographics as one of the best small cities in the midwest and America. Wisconsin offers a wonderful four season recreation-oriented lifestyle and this position with fixed hours will afford the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you would like to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director, Physician Staffing, 1000 North Oak Ave, Marshfield, WI 54449, or call, 1-800-826-2345, extension 5376. 5-8/91

BC/BE internist/family practice physician to join group of three established in NE Wisconsin. Weekday schedule; flexible hours; excellent salary and benefits. Artwich Clinic, Oconto Falls, WI 54154. p4-6/91

Physicians Exchange

Continued

BC/BE obstetrician/gynecologist-Door County, Wisconsin. Live in Door County year around. BC/BE OB/GYN to join established BC/GYN in hospital-based practice. Complete facilities available. New LDRP birthing center in modern, progressive 89-bed community hospital. Competitive guaranteed salary, incentive package, malpractice insurance. Attractive benefits. Door County offers exceptional four seasons recreation along Lake Michigan shores, proximity to Milwaukee and Chicago. Top-rated schools. Quality community life for family. Send CV to: Richard C. Murray, MD, 330 South 16th Place, Sturgeon Bay, WI 54235. p5-7/91

Family practice or internal medicine. Riverview Clinic, a 60-member multi-specialty facility has a position available at our regional clinic in Delavan. No night calls or hospitalization responsibility. Excellent lifestyle and benefits in beautiful southern Wisconsin. Send CV to Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 5-7/91

Madison, Wisconsin. Positions available: internal medicine & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Independent medical examinations. All of us in medicine share the goal of leading our discipline, while maintaining a profitable practice. At CHIRON, LTD, physicians enjoy the advantages of professional independence and substantial compensation. CHIRON, LTD, is the largest provider of Independent Medical Examinations (IME) in the state of Wisconsin. Thanks to strong growth, we are seeking experienced board-certified orthopedic surgeons, neurosurgeons, neurologists, and physiatrists. As an independent contractor to CHIRON, LTD, you enjoy the freedom and the flexibility to work full or part-time in our office or receive referrals directly to your office. **Substantial compensation, set your own schedule, supplement your current practice, prompt payment with no discounts, no investment or billing collection, openings for active and retired physicians**. CHIRON'S quality assurance program, under the direction of James M. Huffer, MD, orthopedic surgeon, will provide you with all the necessary support to insure that our excellent level of service standards is maintained. To learn more, please send a curriculum vitae today, or call CHIRON at 608-231-3030 (FAX 608-231-2848). Contact: Michael J. Foley, MS, CRC, Operations Director, CHIRON, LTD, 2870 University Ave, Ste 206, Madison, WI 53705. 5-6/91

Baraboo, Wisconsin. Seeking internist, family practitioner, general surgeon and emergency department physician. Growing practices require additional physicians in a beautiful, growing rural community. Contact Thomas Warwick, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608-356-1400. 5-10/91

Waukesha. Qualified FPs and internists needed to join busy practices. Give excellent medical care and get quick start-up, rewarding income, shared call and coverage with capable board-certified colleagues, first-class hospital, satisfying lifestyle, thriving community. Contact Amy Palmer, Professional Relations Director, Waukesha Memorial Hospital, 414-544-2120 (toll-free, 1-800-326-2011), in confidence. p5-6/91

Emergency medicine. Emergency department director and staff positions are available at several client hospitals in Wisconsin and Michigan. Communities include Watertown and Chippewa Falls, Wisconsin, and Ironwood, Michigan. ED volumes range from low to moderate. Flexible scheduling with 24-hour shifts available. Competitive fees, allowance for professional dues and CME, assistance with relocation expenses are made available to Spectrum independent contract physicians. Director also offered benefit package and annual administrative stipend. For specific details, contact Mallarry Dierkes, Spectrum Emergency Care, PO Box 27352, St Louis, MO 63141; 1-800-325-3982, extension 1029. 5-7/91

Physician Clinical Director
City of Milwaukee

Make an important contribution to community health. Involves substantial sexually transmitted disease (STD) clinical supervision and program planning. Also oversee employee health and serve as consultant on general medical clinic matters. Requires medical degree in adult medicine (Ob/Gyn, internal medicine, emergency medicine, etc) and at least two years of clinical experience with extensive STD involvement. Salary range: $57K to $80K with excellent benefits. Please indicate interest by sending resume to: Dr Dan Carson, City of Milwaukee Personnel, Box CD, Room 706 City Hall, 200 East Wells St, Milwaukee, WI 53202-3554. An affirmative action employer. 5-6/91

Iowa practice opportunity in Estherville. Family physician needed to join established rural clinic. Located close to outdoor recreational areas, offers easy access to larger metropolitan cities in Iowa and Minnesota. Competitive salary and signing bonus available. Opportunity of practice ownership. Contact Bill Tendle, LifeSpan, 800 East 28th St, Minneapolis, MN 55407; ph 1-800-248-4921. 4-6/91

Community of 2,000, 50 miles NE of Minneapolis/St Paul, seeks additional family practitioner. Located on the St Croix River and Minnesota border. Practice consists of 13 family practitioners, 2 internists, 2 general surgeons and 1 orthopaedic surgeon. Many specialists available on a part-time basis. Attached to a 90-bed hospital with comprehensive services available. Very stable medical group with pleasant working conditions in a continuous growth mode. Guaranteed first year salary with second year partnership. Fringes include excellent retirement package and car. Contact Lenny Libis, administrator at 715-483-3221. 4-9/91

Internal medicine physician board-certified/board eligible to join 25 physician multi-specialty group in Winona, Minnesota, with existing ten physician internal medicine department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact: J.B. Knuesel, Administrator, Winona, Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 4-6/91

Family practice, Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multi-specialty groups of thirty-five. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful wooded Wisconsin areas with an abundance of lakes, rivers, and streams.

Mantiwoc, Wisconsin. The Manitowoc Clinic, an 18-physician multi-specialty group is seeking BC/BE general internists and obstetricians/gynecologists. Excellent practice, financial and quality of life opportunity. Send CV or contact James Robinson, Administrator, 601 Reed Avenue, Box 1270, Manitowoc, WI 54221-1270. Telephone (414) 682-8841. 4-6/91

MANITOWOC CLINIC
601 Reed Avenue, Manitowoc, WI 54220

Physicians Exchange

Continued

All are ideally suited for physicians seeking to combine professional excellence in a midwest, family-oriented location offering exceptional four season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in those communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449 or call 1-800-826-2345, extention 5376. 4-7/91

General internal medicine, Marshfield Clinic, 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

General surgeon to join a progressive 12-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 4tfn/91

Emergency medicine, Marshfield Clinic-Lakeland Center, located in the beautiful Lakeland area of northern Wisconsin, is seeking an ER physician. This individual must be BE/BC in FP, IM, or EM. This opportunity offers a challenging variety of patients, within a multi-specialty group representing thirteen specialties available for back-up. The Lakeland area offers a unique recreation oriented lifestyle and this position with a 48 hour work week will afford you the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you want to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

Experienced BC psychiatrist with interest in the psychological problems of the medically ill. Want to develop adjunctive treatment protocols that integrate both mind/body and psychology of healing models in specific short and long-term caseloads. Programs would be in support of basic medical treatment and include survival strategies for chronic and life-threatening illness. Would like to establish contact with anyone in or near the Milwaukee area having a similar interest or specific need. Contact: Psychiatrist, 1545 West spruce Ct, Milwaukee, WI 53217-1128; ph 414-351-4034. 4-6/91

Internal medicine - Green Bay, Wisconsin. Thirty-one Dr multi-specialty group, ten Dr IM department. Guaranteed first year salary with incentives plus excellent benefits. Excellent patient base in well respected practice. University community with diverse economic base and excellent schools. Superb quality of life and water and land recreational opportunities. Contact John M. Blackburn, Administrator, West Side Clinic, sc, PO Box 19070, Green Bay WI 54307; ph 414-496-4700. 4-6/91

Family practice. Three-physician group seeks fourth MD(BC/BE) to join growing practice located within one hour of Madison and Milwaukee. Full benefits, first-year salary guarantee. One hundred and two bed community hospital located within one block from office. Send resume to Richard C. Holden, MD, PO Box 49, Watertown, WI 53094; ph 414-261-5204. 4-6/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 2-6/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

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Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

Urologist. Beautiful southern Wisconsin. BC/BE urologist to join 60-member multi-specialty clinic adjacent to 250-bed hospital. Community of 55,000 with excellent lifestyle. Good benefits and salary guarantee with full partnership after one year. Send CV to: Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St., Janesville, WI 53545. p2-7/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

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Medical Meetings-Continuing Medical Education

July 31 - August 4, 1991: Annual Convention of IDAA at Hyatt Regency Hotel, Vancouver, British Columbia. Info: IDAA 1991, All Destinations Travel, 1290 Homer St, Vancouver, BC, Canada V6B 2Y5; ph 604-683-6966. g4-6/91

September 20-21, 1991: "Issues in Primary Care," at Landmark Inn Resort, Egg Harbor. For more information contact: Nadine Punke, Office of Medical Education, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449; ph 715-387-5207. 6-8/91

September 20-21, 1991: American College of Surgeons - Cancer Management Course, at Department of Surgery, Mayo Clinic, Siebens Medical Education Building, Mayo Clinic, Rochester,Minn. Info: Dr John Donohue or Dr David Nagorney, Mayo Clinic, Department of Surgery, Rochester, MN 55905; ph 507-284-2644 or to register, Ms Clifola Coleman, Cancer Management Course, American College of Surgeons, 55 East Erie St, Chicago, IL 60611-2797; ph 312-664-4050. p5-7/91

September 25-27, 1991: "The treatment of panic disorder," at the Masur Auditorium, The Warren Grant Magnuson Clinical Center, NIH, Bethesda, Md. Info: Conference Registrar, Prospect Associates, 1801 Rockville Pike, #500, Rochville Md 20852; ph 301-468-6338. g6-8/91

October 10-13, 1991; American Society of Internal Medicine 35th Annual Meeting at J.W. Marriott Hotel, Washington, DC. Category 1 CME credit will be available. Info: Lisa Derby at 202-289-1700, ext 615. g6-9/91

Medical Meetings-Continuing Medical Education

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

Nov 7-10, 1991: 10th Annual Scientific Meeting of the American Pain Society at the New Orleans Hilton, New Orleans, La. Info: APS, 5700 Old Orchard Rd, 1st Fl, Skokie, IL 60077; ph 708-966-5595. g4-8/91

AMA

June 23-27, 1991: Annual AMA House of Delegates, Chicago.
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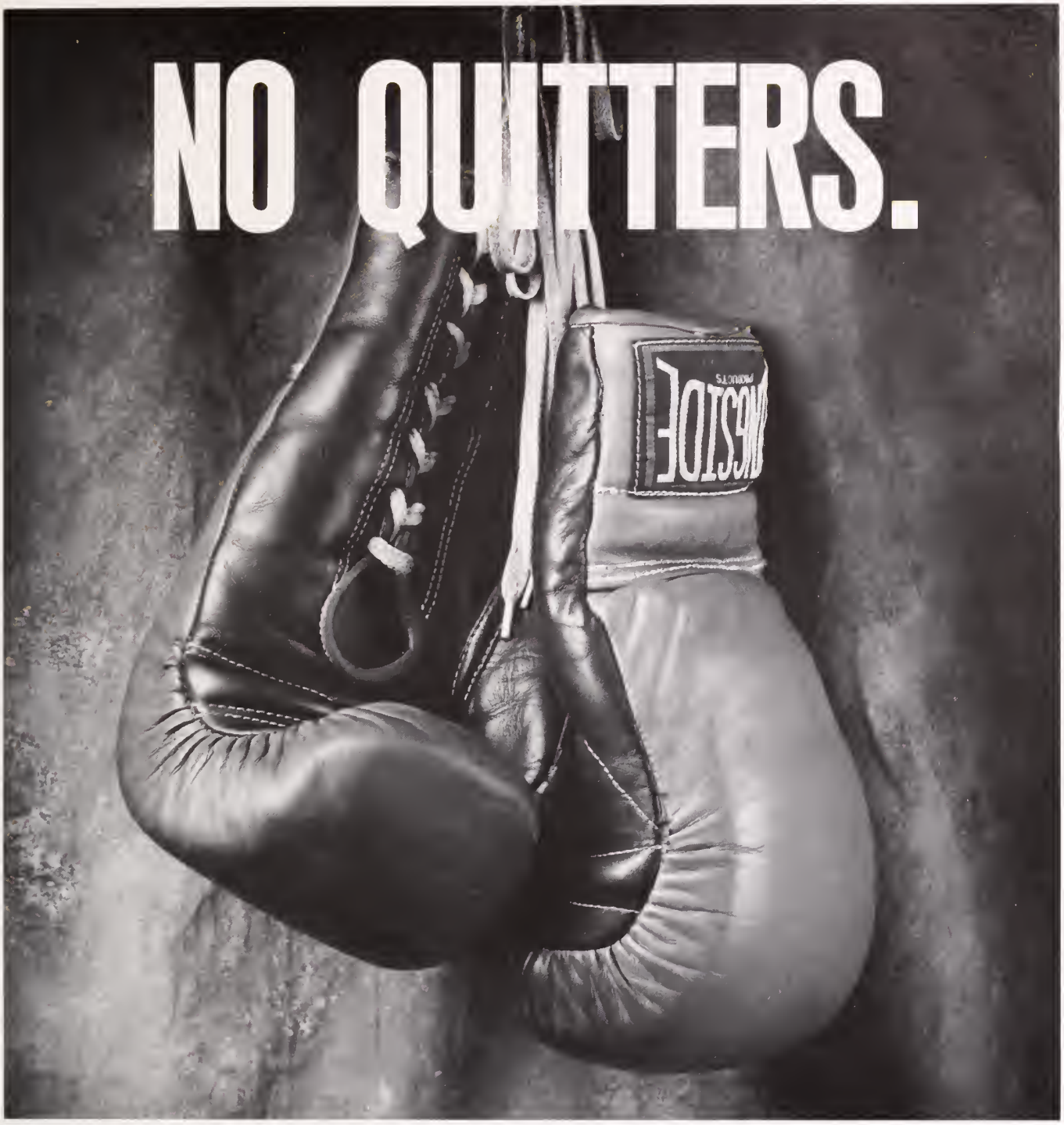

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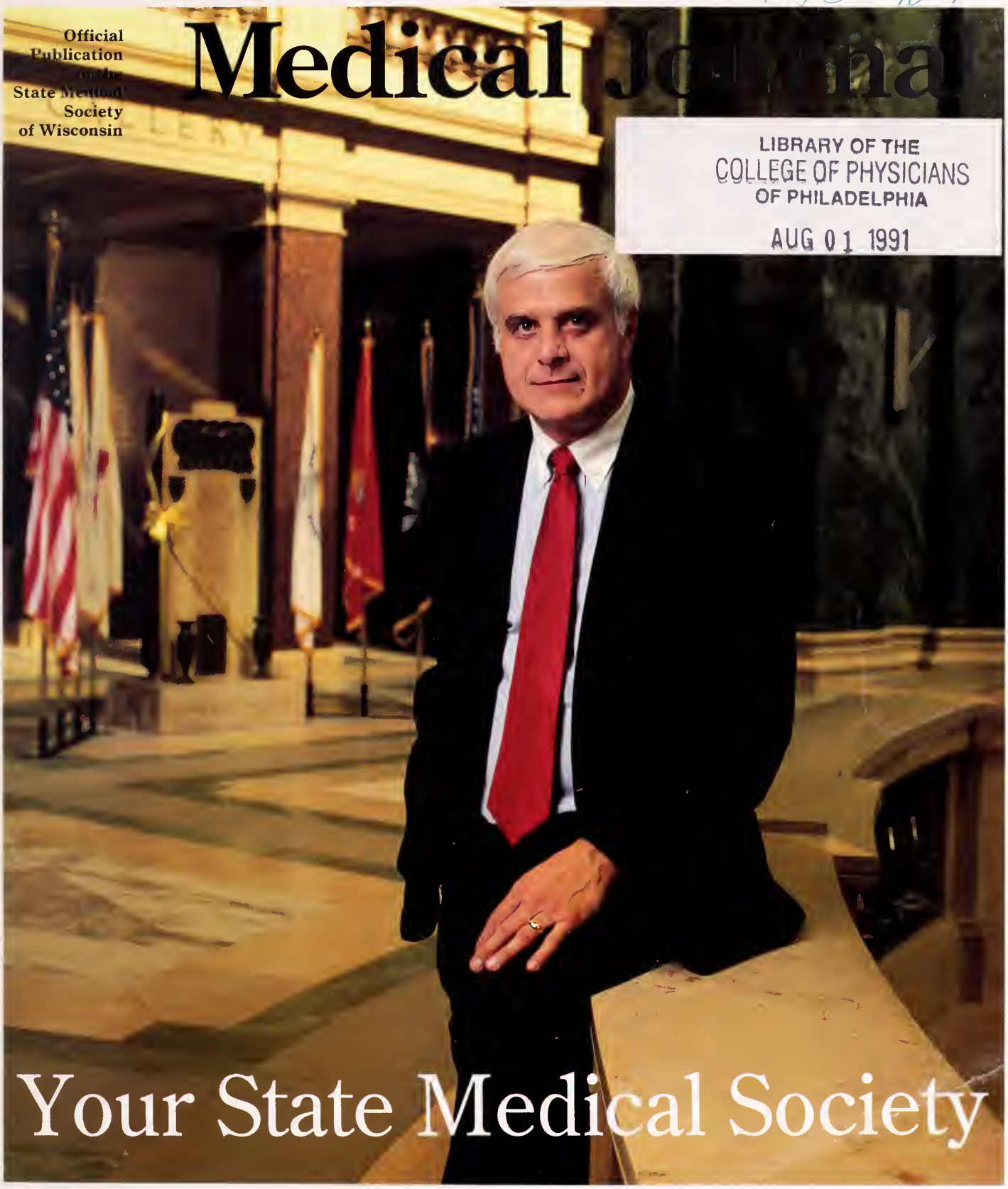

Your State Medical Society

July 1991

Wisconsin Medical Journal

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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July 1991 Vol. 90 No. 7

Opinions

323 *President's page*
'Medicina nusquam non est' (medicine is universal): II
by Cyril M. "Kim" Hetsko, MD, Madison
324 *Secretary's report*
Twisting a good idea into bad
by Thomas L. Adams, CAE, Madison
326 *Soundings*
If I had taken the time
by Philip J. Dougherty, MD, Menomonee Falls

Organizational

329 SMS Officers and directors: 1991-1992
340 SMS commissions, committees and task forces: 1991-1992
352 Expense reimbursement policy and procedure for physicians on SMS business
353 SMS financial report
354 SMS placement service aids physicians and communities
355 Charter law of the SMS
356 SMS Constitution and Bylaws
364 Officers of Wisconsin's county medical societies
369 Officers of the SMS special sections
373 Presidents and secretaries, Wisconsin specialty societies
376 Impaired Physician Program
378 SMS physicians' support group
379 Mediation and peer review services
380 Accreditation program for continuing medical education
381 Membership facts
382 SMS officers and directors by district
385 SMS resource directory
390 Publications and reprints available
391 Physician briefs
392 WISPAC and Physicians for Better Government
393 Obituaries

Continued on next page

Our cover: SMS President Cyril M. "Kim" Hetsko, MD, has made responsible health care legislation and public policy the theme of his presidential term.

Continued from preceding page

Annual meeting

395 House actions on resolutions and reports
404 House of Delegates: 1991
406 *Presidential report*
The presidential medallion: a symbol of strength
by Roger L. von Heimburg, MD, Green Bay
408 *Address of the president elect*
Building access to quality medicine
by Cyril M. "Kim" Hetsko, MD, Madison
413 *Secretary's address*
A profession worth fighting for
by Thomas L. Adams, CAE, Madison
416 Awards presented at the SMS annual meeting

CES Foundation

421 The history of the CES Foundation
422 Facts about the CES Foundation
423 A CESF guide to gifts
424 The Fort Crawford Medical Museum
425 Foundation grant allocations

Scientific

427 The potential for the elimination of measles in the modern age
by Kenneth C. Goldberg, Shorewood
434 Music therapy: a means of reducing anxiety in the myocardial infarction patient
by Jill White, RN, BSN, and Christine Shaw, RN, PhD, Milwaukee
438 Family protective thinking about cardiac events: nursing interventions to promote maintenance of family health behaviors
by Lori A. Wastlick, RN, MSN, and Kathryn Hoehn Anderson, RN, PhC, Eau Claire
441 Correction

Socioeconomic

443 *Public health*
The Wisconsin Farmers Cancer Control Project
by Douglas Reding, MD; Henry Anderson, MD; Karen Lappe, RN; Lawrence Hanrahan, MS; and Linda Haskins, Madison
446 Physicians Insurance Company of Wisconsin: state of the corporation
448 HCFA tries to balance the budget with RBRVS
449 Private insurance billing issue heats up

President's page

'Medicina nusquam non est'

(medicine is universal): II

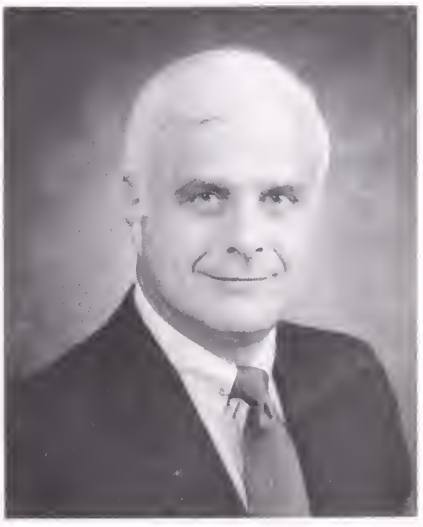
THE ISSUES OF ACCESS to health care and health care costs continue to percolate this summer with the SMS and the AMA encouraging discussions of these important concerns.

As I pointed out in my inaugural address in April in Milwaukee (printed elsewhere in this issue), access and the cost of high quality care have become major public concerns. In May, JAMA devoted an entire issue to this subject, and several proposals have been coming forth in Congress. Various groups in Wisconsin also are developing proposals, including some of the excellent points that have come from the Wisconsin Health Care Forum. Our profession should continue to seize this era of opportunity to improve on the strengths of our excellent health care system.

Certainly, by many measures we have one of the best health care systems in the world, with people coming from all parts of the globe to avail themselves of the high quality and high tech care available in this country. Americans are living longer, and there has been a 6% decline in infant mortality nationwide in the past year. Recent Gallup polls across this country and in Wisconsin show that the public is overwhelmingly satisfied with: 1) their last visit to their doctor, 2) their access to specialists when they are needed, and 3) their access to the latest technology. Of the last 30 Nobel prizes given in medicine, 20 have gone to MDs working in the United States.

While economists point to medicine as a fairly inelastic market place (for a number of reasons), we must be wary of some of the rubrics of rationing and price controls. Historically, some price controls have not worked except for an extremely short period of time such as in World War II, and certainly rent controls in New York City have had long term disasterous effects. We must remember that we, as Americans, tend to want the best and want it now. The potential changes and pitfalls of centralized rationing are vividly demonstrated with the current example of eastern Europe. There are solid values in preserving the opportunities of diversity in free choice, with innovation and experimentation while minimizing stagnation and bureaucratic misallocations of resources.

My hope is that the issue of access to high quality, cost-effective care will remain a non-partisan discussion, and that we will move to solutions with all sorts of diverse approaches respectfully and openly considered. All sectors of American society (physicians, patients, hospitals, insurance companies, employers, employees, and the state and federal governments) must take responsibility in meeting their obligations of achieving this goal. I urge all of my colleagues to be an integral part of the process.



Cyril M. "Kim" Hetsko, MD

The train is leaving the station. We had better be on board with organized medicine at both the state and national levels to have input in helping to guide it down the track.□

Secretary's report
Twisting a good idea into bad

Thomas L. Adams, CAE

YOU'VE BEEN HEARING about it for some time now. Physician Medicare payment reform, aka the RBRVS, has arrived. The new system is approaching the door and will very shortly demand admittance to your life. The future is almost here, and if you look out the window you can see in the sky that something ominous this way comes. It appears to be evolving into a different animal than we expected–much different than the one we had agreed to accept. If the door opens and admits this creature, the house of medicine will change forever.

The nation has been demanding good ideas for shoring up the weak spots in the American health care system, and the RBRVS was one such idea. Physicians agreed that Medicare payments were inequitable and in need of reform, then worked with Harvard and HCFA to bring the idea to fruition. Now, HCFA is abusing that cooperation and reneging on the deal. HCFA is twisting a good idea into bad.

You received an SMS call to action in June, and if you have not yet followed through, please do. Medicine supported payment reform because Congress and the Bush administration gave assurances that reforms would be implemented fairly and not used to simply save dollars in the federal budget. In fact, Congress stipulated that the reforms be budget neutral. The notice of proposed rule making published by HCFA in June, however, ignores Congressional will by slashing 16% off the initial conversion factor used to translate relative values into specific dollar amounts. HCFA ignores Congressional will by cutting or reversing the projected increases for primary care and rural physicians. And Medicare payment for some surgical procedures will be cut below the Medicaid payments, again ignoring Congressional intent.

The bad news is that HCFA is trying to use the RBRVS as a budget-cutting tool; the good news is that there is still time for physicians to fight back. Congress must be alerted to HCFA's disregard for Congressional intent. And Congress must be made aware of the disastrous affects HCFA's callous cuts would have on access to health care in America. The members of Wisconsin's Congressional delegation–all 11 of them–must hear from Wisconsin's physicians early and often. You will find their names, addresses and telephone numbers on this page. Use them.

Wisconsin's Congressional delegation must also hear from your patients, which means I am about to ask something extraordinary of you. As distasteful as it may seem, the time has come to talk to your patients about the direction medicine is being pushed by the federal government. The time has come to describe to them the fiasco created by Medicare and Medicaid and to warn them that more of the same may lurk ahead. The time has come to talk to them about underfunding for government health care delivery programs, about sacrificing America's health in misguided attempts to balance the budget, and about health care rationing. You don't need to go into detail or load them down with numbers, just take an extra 5 minutes to give them the problem in a nutshell and urge them to help.

Now is the time for unity among and action by physicians. If we fail each other now, the house of medicine may be a very dark place for a very long time.❑

Wisconsin members of congress

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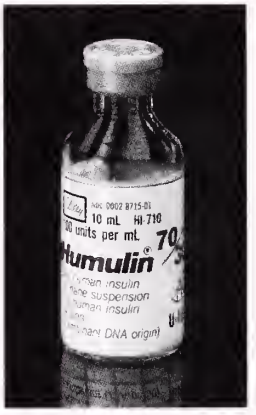

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Soundings

If I had taken the time

Philip J. Dougherty, MD, Menomonee Falls

I FIRST MET MARY about 25 years ago, as the vibrant wife of a laborer and the mother of two children, an adult boy and girl. She eventually developed an Alzheimer's dementia.

About 10 years ago, Mary's Alzheimer's syndrome progressed and she had to be placed in a nursing home. Mary declined thereafter, ultimately becoming vegetative.

Eight years ago, Mary's husband, Mike, retired–usually a happy event--but Mary didn't know it.

Six years ago, Mike had a massive stroke, and died–but Mary didn't know it.

Five years ago, her son developed lung cancer and had surgery and radiation therapy–but Mary didn't know it.

Three years ago, her son died of his cancer but Mary didn't know it.

Two years ago, her daughter underwent a mastectomy for cancer but Mary didn't know it.

Over the years, two or three times a year, Mary would spike a fever, frequently from pneumonia, frequently from aspiration, and sometimes from urosepsis. I reflexly would place her on antibiotics in the nursing home and she would respond. Last fall, another episode of pneumonia occurred, but I received a phone call from her daughter, now 65, who asked "Doctor, do we have to treat her with medicine? Can't we just let her go?"

And that's what I did.

Mary lingered about 5 days. She was given oxygen and was kept warm and clean, and attempts were made to feed and give her water, until she died quietly and peacefully. I called her daughter and said, "Edna, I am calling to tell you that your mother just passed away."

She thanked me and said that I was wrong. Her mother had died 10 years ago; the body in that bed was truly not her mother.

I almost felt as though I should have apologized for the past 10 years. If only from the viewpoint that I had not had the courage–or taken the time–to initiate the discussion that would have allowed us to reach a consensus as to treatment decisions back then. Mary would have been at rest a long time ago, society would have spent thousands of dollars less, and maybe–just maybe–Mary would have known.❑

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Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701. ❑

Dr Humerus?

Rumor has it that physicians take themselves too seriously, and the *WMJ* Editorial Board wants to prove the rumor wrong. The Board wants to hear your best doctor jokes - no holds barred. Publication is possible. Send them to: Doctor Jokes, c/o *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❑

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Medical Writing Contest

Contestants:
- Medical students enrolled in either of Wisconsin's two medical schools
- Residents actively training in Wisconsin

Awards:
- One student; one resident
- Recognition certificate
- $500
- Publication in the *Wisconsin Medical Journal*
- Presentation at the 1992 SMS Annual Meeting

Rules:
- Subject matter must fall within the parameters of scientific medicine: clinical, case report, research and review
- Paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- Limited to 10 pages, typewritten, double-spaced, 1-inch margins
- Illustrations are encouraged, but must be included in the 10-page length limit
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority in all decisions

Criteria:
- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *Applicability:* usefulness of results to private practitioner, academician, researcher
- *Content:* depth of analysis, continuity of discussion supporting the main thesis, feasibility of conclusions
- *Innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, advancement of basic understanding
- *Organization*
- *Clarity of writing*

Deadline: Entries must be received by the *Wisconsin Medical Journal* no later than February 14, 1992: PO Box 1109, Madison, WI 53701

SMS officers and directors: 1990-1991

Cyril M. (Kim) Hetsko, MD
Madison
President
(1991-1992)
Dr Hetsko graduated from the University of Rochester School of Medicine and Dentistry and completed his internship and residency and was chief resident at the University of Wisconsin Hospitals. He has been a member of the Dean Medical Center since 1975 and is a clinical associate professor of medicine at the University of Wisconsin, Madison. Dr Hetsko is active in the Wisconsin Society of Internal Medicine, serving as president from 1987 to 1988. He is chair of the SMS Task Force on AIDS. In addition, he was vice speaker of the SMS House of Delegates; a member of the Task Force on RBRVS, Strategic Planning Committee, and Task Force on Physician Discipline and Review; and served on the SMS Board of Directors for 9 years and was chair of its Finance Committee. He has been a member of the Wisconsin delegation to the AMA since 1983, serving as alternate delegate and secretary. He is a past chair of the Department of Medicine at St Mary's Hospital Medical Center, Madison, and was a member of its Medical Staff Executive Committee. He is currently a member of the Infection Control and Pharmacy and Therapeutic committees, as well as a past member of its Institutional Review Board. He has received the Presidential Award from the Dane County Medical Society and the SMS Meritorious Service Award.

William J. Listwan, MD
West Bend
President elect
(1991-1992)
Dr Listwan graduated from the Medical College of Wisconsin and specializes in internal medicine. He has been a member of the SMS Board of Directors since 1984. He has served

Continued on next page

Cyril M. "Kim" Hetsko, MD

William J. Listwan, MD

Thomas L. Adams, CAE

Pauline M. Jackson, MD

Roger L. von Heimburg, MD

Richard G. Roberts, MD, JD

Kenneth I. Gold, MD

Richard H. Ulmer, MD

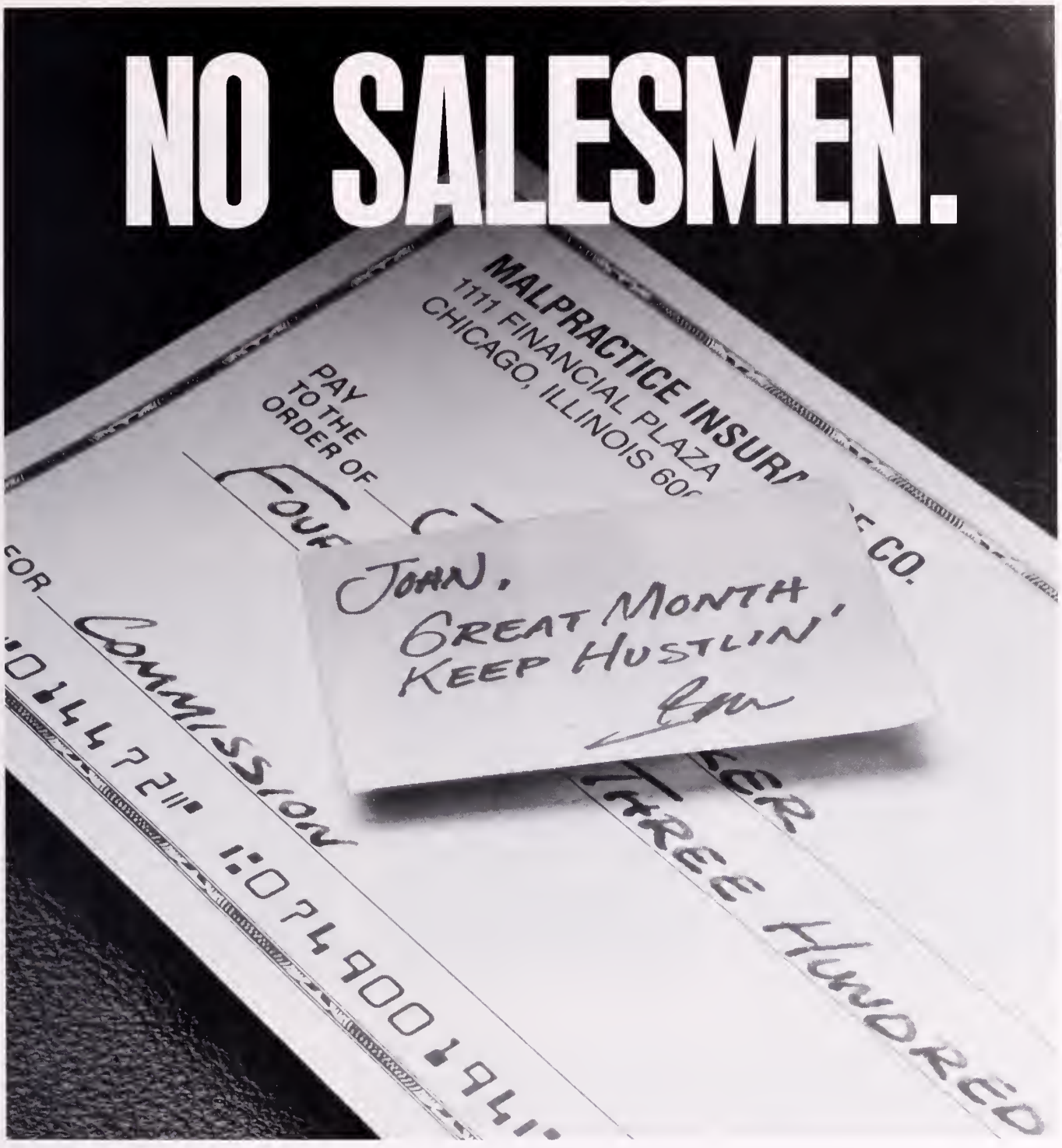
Raymond C. Zastrow, MD

Continued from preceding page
as a member of the Physicians Alliance Commission and chair of the Medical Liability Committee. Dr Listwan also serves on the Task Force on Alternatives to Tort Reform. He is a member of the Physicians Insurance Company of Wisconsin board of directors. Dr Listwan was elected president of the Washington County Medical Society and served from 1976 to 1977. He also served as president of the Wisconsin Society of Internal Medicine from 1989 to 1990. Dr Listwan is currently a member of the WISPAC board. He currently serves as medical director of respiratory therapy at St Joseph's Community Hospital and as medical director for several West Bend industries.

Thomas L. Adams, CAE
Madison
Secretary-General Manager
(1991-1992)
Thomas L. Adams was named secretary-general manager of the SMS in 1987. Adams was director of the Washington, DC, office of the American Society of Anesthesiologists prior to joining the Society in 1986 as secretary-general manager designate. Adams served as assistant executive director and lead lobbyist for the North Carolina Medical Society from 1978 until 1983, when he joined the anesthesiology group. Adams graduated from Lenoir Rhyne College in Hickory, NC.

Pauline M. Jackson, MD
La Crosse
Treasurer
(1991-1992)
Dr Jackson graduated from Stanford University Medical School and served her internship at Charles T. Miller

Continued on page 332



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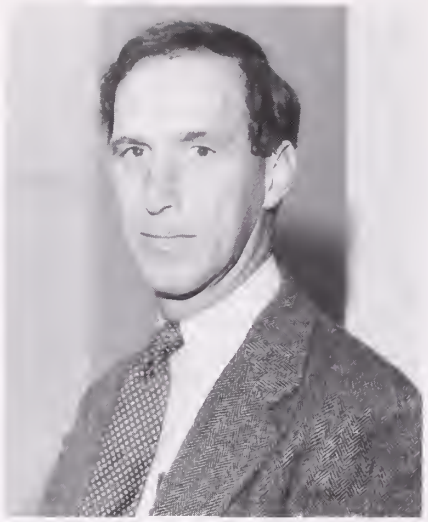
Robert F. Purtell, Jr, MD



Jay F. Schamberg, MD

Marvin G. Parker, MD

George R. Schneider, MD

Richard H. Strassburger, MD

Thomas A. Reminga, MD

Continued from page 330

Hospital in St Paul, Minn. Board certified in psychiatry, she completed her residency at the Cleveland Psychiatric Institute. Dr Jackson is an ex-officio member of the SMS Board of Directors, and is a member of both the Mental Health Committee and the Physicians Alliance Commission. She served as president of the La Crosse County Medical Society from 1984 to 1985, and as secretary of the Wisconsin Psychiatric Association (president in 1987 to 1989). Dr Jackson served on the board of directors of the Gundersen Clinic and as chief of staff at Lutheran Hospital in La Crosse.

Roger L. von Heimburg, MD
Green Bay
Immediate Past President
(1991-1992)

Dr von Heimburg graduated from, and completed a surgery internship at, the Johns Hopkins University School of Medicine in Baltimore. He completed his surgical training at the Mayo Clinic where he also served for 2 years as assistant to the staff in surgery. He was a member of the SMS Board of Directors from 1980 to 1989, serving as vice chair from 1983 to 1987 and chair from 1987 to 1989. Dr von Heimburg was president of the Brown County Medical Society in 1986. He is a past president of the Wisconsin Chapter of the American College of Surgeons and also served on the Council of the Wisconsin Surgical Society. In addition, he is chair of the SMS Blue Ribbon Task Force on Alternatives to the Tort System and a member of the State Board of Health Care Information.

Marcia J. S. Richards, MD

Frank Urban, MD

John E. Ridley, III, MD

Timothy G. McAvoy, MD

Charles E. Pechous, Jr, MD

William L. Kopp, MD

Richard G. Roberts, MD, JD
Madison
Speaker, House of Delegates
(1991-1993)
Dr Roberts graduated from George Washington University Medical School in Washington, DC. He is an associate professor of family medicine at the University of Wisconsin, Madison. Dr Roberts is vice chair of the SMS Medical Liability Committee and a member of the Blue Ribbon Task Force on Alternatives to the Tort System. He was first elected speaker of the House in 1987. He also serves on the American Academy of Family Physicians' Commission on Legislation and Government Affairs and the Task Force on Clinic Policies for Patient Care. He is a past president of the Wisconsin Academy of Family Physicians. In addition, Dr Roberts serves as an SMS representative on the board of governors of the Patients Compensation Fund and the Wisconsin Health Care Liability Insurance Plan.

Kenneth I. Gold, MD
Beloit
Vice speaker, House of Delegates
(1990-1992)
Dr Gold, whose specialty is internal medicine, graduated from the State University of New York-Downstate. He completed a residency in internal medicine at University Hospital in Columbus, Ohio, and a fellowship in psychiatry and medicine at Strong Memorial Hospital, Rochester, NY. Dr Gold served on the SMS Commission on Continuing Medical Education for 9 years, and was chair for 3 years. He is currently chief of staff at Beloit Memorial Hospital, and has served as president of Rock County Medical Society, president of

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Continued from preceding page
Wisconsin Society of Internal Medicine, and a secretary for the Wisconsin Chapter of American College of Physicians. He is an editorial associate of the *Wisconsin Medical Journal.*

Richard H. Ulmer, MD
Marshfield
Chair, Board of Directors
Director, District 4
(1989-1992)
Dr Ulmer was elected to the Board of Directors in 1986 and served as vice chair from 1987 to 1989 at which time he was elected chair. A graduate of the Stritch School of Medicine at Loyola University in Chicago, he specializes in internal medicine and cardiovascular diseases. He completed a rotating internship and residency at the University of Chicago Hospital. He was a member of the House of Delegate's Nominating Committee from 1978 to 1980 and has served as an alternate delegate to the AMA since 1983. He is a past president of the Wood County Medical Society.

Raymond C. Zastrow, MD
Milwaukee
Vice chair, Board of Directors
Director, District 1
(1989-1992)
Dr Zastrow, who specializes in clinical pathology, graduated from Marquette University School of Medicine (now the Medical College of Wisconsin). He served on the SMS Physicians Alliance Commission from 1977 to 1989 and is a member of the WISPAC Board of Directors. He served as chair of the SMS bylaws committee, a member of the Finance Committee and was an alternate delegate to the AMA in 1983 to 1984. Dr Zastrow has also served on the SMS ad hoc committee on the Health Policy Agenda for the American People (HPA).

Robert F. Purtell, Jr, MD
Milwaukee
Director, District 1
(1989-1992)
A family physician, Dr Purtell graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) in Milwaukee and served an internship at Misericordia Hospital. He completed a residency at St Joseph's Hospital, also in Milwaukee. Dr Purtell was a member of the SMS Physicians Alliance Commission from 1977 to 1989, having served as chair. He is also active in the American Academy of Family Physicians (AAFP) and serves as an SMS alternate delegate to the AMA. He is a member of the Wisconsin delegation to the AAFP, a past president of the Wisconsin Academy and a past president of the Marquette-Medical College of Wisconsin Medical Alumni Association.

Jay F. Schamberg, MD
Waukesha
Director, District 1
(1991-1993)
A pathologist, Dr Schamberg received his medical degree from Hahneman Medical College and served his internship at Chestnut Hill Hospital in Philadelphia. Dr Schamberg completed his residency at the Peter Bent Brigham Hospital in Boston and the University of Vermont Hospital in Burlington. He serves on the medical staffs of Community Memorial Hospital and West Allis Memorial Hospital. Dr Schamberg is president elect of the Wisconsin Society of Pathologists and a past president of Waukesha County Medical Society.

Marvin G. Parker, MD
Racine
Director, District 1
(1990-1993)
An hemotologist, Dr Parker received his medical degree from Washington University in St Louis, and served his residency and fellowship in internal

Peter L. Eichman, MD

Ayaz M. Samadani, MD

Sandra L. Osborn, MD

medicine and hemotology at the University of Missouri. Dr Parker began practice in Racine in 1966, and since 1986, has been vice president of Corporate Medical Affairs at Johnson Wax.

George R. Schneider, MD
West Allis
Director, District 1
(1991-1994)
A specialist in internal medicine, Dr Schneider graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) in Milwaukee and served an internship at the University of Missouri Medical Center in Columbia. He also completed a residency at the Medical College. Dr Schneider is a member of the American Society of Internal Medicine and the American College of Physicians.

Richard H. Strassburger, MD
Cudahy
Director, District 1
(1991-1994)
Dr Strassburger received his medical degree from St Louis University. A specialist in neurosurgery, he served an internship at Milwaukee County Hospital and residencies at Milwaukee County Hospital and the University of Minnesota. Dr Strassburger is also a director of the Medical Society of Milwaukee County.

Thomas A. Reminga, MD
Milwaukee
Director, District 1
(1989-1992)
Dr Reminga, whose specialty is emergency medicine, graduated from the University of Michigan Medical School. He was a member of the SMS Health Planning Commission, has served as an alternate delegate to the SMS and is currently a member of the Finance Committee. He has served as president of the Medical Society of Milwaukee County, and as secretary-treasurer from 1983 to 1984.

Marcia J.S. Richards, MD
Milwaukee
Director, District 1
(1990-1993)
Dr Richards received her medical degree from the University of Wisconsin Medical School in Madison and completed an internship and a residency at University Hospitals. A board-certified specialist in radiation oncology, she is currently director of radiation oncology at St Luke's Medical Center in Milwaukee and is a past president of the Medical Society of Milwaukee County. She has also served as secretary-treasurer of the organization and is a past president of the Wisconsin Society of Radiation Oncologists. Dr Richards has been a delegate to the SMS since 1983. She is active in the Wisconsin Division of the American Cancer Society, having served as chair of its Breast Cancer Detection Awareness Project and as a member of its board of directors, and is currently chair of the Professional Education Committee.

Frank H. Urban, MD
Wauwatosa
Director, District 1
(1990-1993)
Dr Urban graduated from the University of Wisconsin Medical School and completed his dermatology residency at the Mayo Foundation in Rochester, Minn. He is a past president of the Wisconsin Dermatological Society and is active in the Medical Society of Milwaukee County and the American Academy of Dermatology. He also served on the SMS Task Force on Health Care for the Uninsured. Dr Urban received the Civic Leadership Award of the SMS in April 1990. Dr Urban is also a Wisconsin state legislator, having been elected to the Wisconsin

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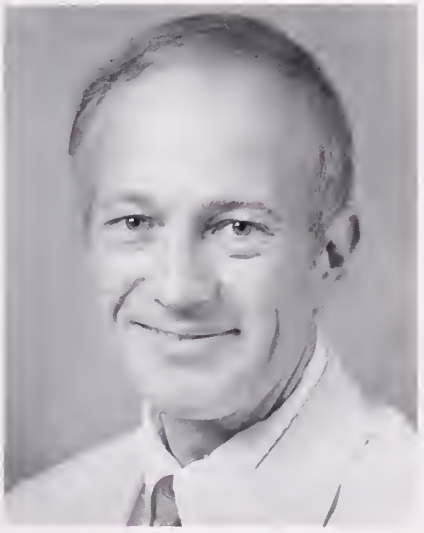
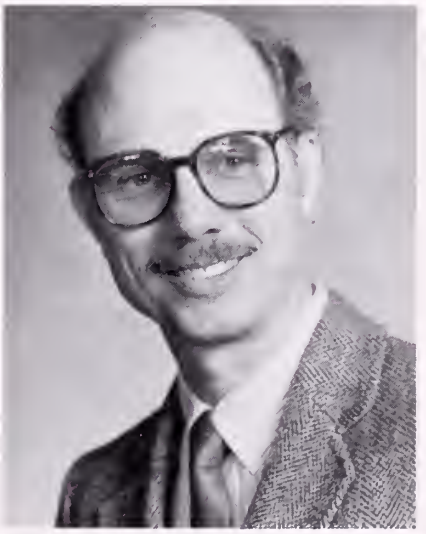


John D. Wegenke, MD



Jan E. Erlandson, MD

Jack M. Lockhart, MD

Continued from preceding page
Assembly in 1989. Dr. Urban recently received the Ralph Hawley Distinguished Service Award from the UW Medical School Alumni Association.

John E. Ridley, III, MD
Milwaukee
Director, District 1
(1990-1993)
Dr Ridley, an ophthalmologist, graduated from the University of Indiana School of Medicine. His residency was completed at the Marquette School of Medicine. He is currently the assistant clinical instructor in ophthalmology at the Medical College of Wisconsin. Dr Ridley served as a captain in the US Air Force from 1961 to 1963. He is a member of the Milwaukee Ophthalmology Society and the American Academy of Ophthalmology.

Timothy G. McAvoy, MD
Waukesha
Director, District 1
(1990-1993)
Dr McAvoy graduated from New York Medical College. Specializing in internal medicine and emergency medicine, Dr McAvoy served his internship at Boston City Hospital. His residency was completed at Boston City Hospital and the University of Wisconsin Hospital and Clinics in Madison. He served as president of the Waukesha County Medical Society and has been a member of the Physicians Alliance Commission since 1987.

Charles E. Pechous Jr, MD
Kenosha
Director, District 1 (1990-1993)
Dr Pechous, a family practitioner and general surgeon, graduated from Loyola-Stritch School of Medicine. His internship and residency were completed at Cook County Hospital in Chicago. Currently, he is the medical director at St Catherine's Hospital in Kenosha. He is a member of the American College of Surgeons and the Wisconsin Chapter of the American College of Surgeons.

William L. Kopp, MD
Madison
Director, District 2
(1991-1994)
Dr Kopp was elected to the Board of Directors in 1989. Board certified in internal medicine and allergy and immunology, he received his medical degree from the University of Michigan and served an internship at St Luke's Hospital in Cleveland. He completed a residency and a fellowship at the University of Michigan. Dr Kopp is a fellow in the American Academy of Allergy and Immunology and the American College of Physicians. He is also a past president of the Dane County Medical Society.

Peter L. Eichman, MD
Madison
Director, District 2
(1990-1993)
Dr Eichman, whose specialties are neurology and internal medicine, graduated from the Jefferson Medical College in Philadelphia. He served as dean of the University of Wisconsin Medical School in Madison from 1965 to 1970. He also served as deputy director of the Federal Bureau of Health Manpower Education and was a member of the SMS Committee on Mental Health. In addition, Dr Eichman has served as chair of the Task Force on Physician Review and Discipline and he was a member of the Commission on Health Planning. He was president of the Dane County Medical Society from 1983 to 1984.

Ayaz M. Samadani, MD
Beaver Dam
Director, District 2
(1991-1994)
A family physician, Dr Samadani

William E. Raduege, MD

Robert J. Jaeger, MD

James L. Basiliere, MD

received his medical degree in Pakistan. He served his internship at Henrotin Hospitals and Illinois Masonic Hospitals in Chicago. He spent 5 years of post graduate training in internal medicine and pediatrics in London. He is a fellow of the Royal Society of Tropical Medicine and Hygiene and certified in child health from the Royal College of Physicians and Surgeons of London. He has been in practice in Beaver Dam since 1971, and is chair of the pediatric department of Beaver Dam Community Hospital and has been in that position for the last 18 years. He has served as secretary and president of Dodge County Medical Society and is president of the Wisconsin chapter of the Association of Pakistani Physicians of North America.

Sandra L. Osborn, MD
Madison
Director, District 2
(1991-1994)
Dr Osborn, whose specialty is pediatrics, graduated from the University of Wisconsin Medical School in Madison. She served as president of the Dane County Medical Society from 1982 to 1983. She has also served on the SMS Committee on Women Physicians, the House of Delegates Nominating Committee, the Credentials Committee and the Reference Committee on Scientific Affairs. Dr Osborn also served on the Ad Hoc Committee on Child Abuse and Neglect.

John D. Wegenke, MD
Madison
Director, District 2
(1989-1992)
Dr Wegenke, a urologist, graduated from the University of Wisconsin Medical School in Madison. He served an internship at San Joaquin General Hospital in Stockton, Calif, and internships in general surgery and urology at University Hospital and Clinics in Madison. He is an editorial associate for the *Wisconsin Medical Journal,* and has served the Dane County Medical Society in various offices, including president.

Jan E. Erlandson, MD
Monroe
Director, District 2
(1991-1994)
Dr Erlandson graduated from the University of Wisconsin Medical School in Madison, and served his internship at Cincinnati General Hospital. His internal medicine residency was completed at the University of Wisconsin Hospitals and Clinics. He served in the US Army from 1969 to 1972. He was chief medical resident at the Middleton Veterans Administration Hospital in Madison before establishing a medical practice at the Monroe Clinic. Dr Erlandson has served as a member of the SMS Task Force on Medical Manpower and the SMS Health Planning Commission.

Jack M. Lockhart, MD
La Crosse
Director, District 3
(1989-1992)
A specialist in rheumatology, Dr Lockhart graduated from Harvard Medical School and served an internship at University Hospitals of Cleveland. He also completed fellowships at the University of Minnesota Medical School in Minneapolis. Dr Lockhart has served as a delegate to the SMS and as a member of the Nominating Committee. He also served on the SMS Physicians Alliance Commission for 9 years and is a member of the SMS Finance Committee and the Executive Committee of the La Crosse County Medical Society.

William E. Raduege, MD
Woodruff
Director, District 4
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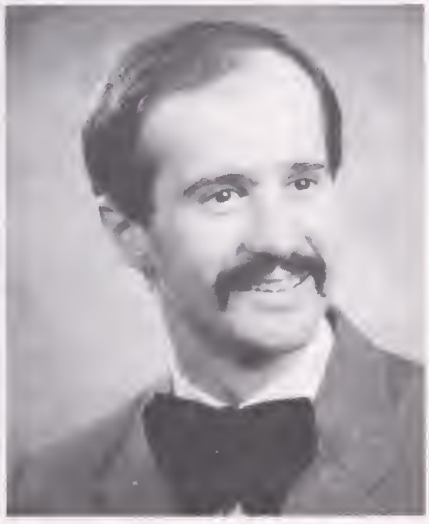

Donn D. Fuhrmann, MD

Harry J. Zemel, MD

Stephen D. Hathway, MD

Joseph C. DiRaimondo, MD

John E. Kraus, MD

Philip J. Happe, MD

Continued from preceding page
(1989-1992)
Dr Raduege was first elected to the Board of Directors in 1986. A family practitioner, he graduated from the University of Wisconsin Medical School in Madison. He served as a member of the SMS Commission on Mediation and Peer Review for 9 years and has been a delegate from Oneida-Vilas County Medical Society since 1977.

Robert J. Jaeger, MD
Stevens Point
Director, District 4
(1991-1994)
Dr Jaeger is a specialist in obstetrics and gynecology. He attended the University of Wisconsin Medical School and served an internship and residency at Milwaukee County General Hospital. Dr Jaeger is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin and serves on the board of directors of the University of Wisconsin Medical Alumni Association. He is chair of the SMS Committee on Maternal and Child Health.

James L. Basiliere, MD
Oshkosh
Director, District 5
(1989-1992)
Dr Basiliere was first elected to the Board of Directors in 1986. A board-certified specialist in internal medicine, Dr Basiliere graduated from the University of Wisconsin Medical School in Madison and served an internship and a residency at the San Diego Naval Hospital. He is a past president of the Winnebago County Medical Society, past president of the Fox Valley Academy of Medicine and past secretary of the Oshkosh Area Physicians Association. Dr Basiliere has been a member of the Board of Directors of the Wisconsin Medical Alumni Association since 1988.

Donn D. Fuhrmann, MD
New London
Director, District 5
(1990-1993)
A board-certified family practice specialist, Dr Fuhrmann graduated from the University of Wisconsin Medical School in Madison, and served an internship there as well. He served a residency at St Luke's Hospital in Milwaukee. Dr Fuhrmann is chief of the medical staff at the New London Family Medical Center and is also an assistant clinical professor at the UW Medical School. He has been secretary of the Waupaca County Medical Society since 1982.

Harry J. Zemel, MD
Fond du Lac
Director, District 5
(1991-1994)
Dr Zemel was first elected to the Board in 1987. He graduated from the University of Missouri School of Medicine and specializes in pathology. Dr Zemel has been chair of the Finance Committee since 1989 and was president of the Fond du Lac County Medical Society in 1979.

Stephen D. Hathway, MD
Green Bay
Director, District 6
(1989-1992)
A pathologist, Dr Hathway graduated from the Indiana University School of Medicine in Indianapolis and completed an internship and residency at the South Bend Medical Foundation in South Bend, Ind. Dr Hathway is a member of the SMS

Marwood E. Wegner, MD

Robert L. Sellers, MD

Health Care Financing and Delivery Committee and served on the Committee on Alcoholism and Other Drug Abuse. He is also a past secretary of the Brown County Medical Society.

Joseph C. DiRaimondo, MD
Manitowoc
Director, District 6
(1991-1994)
Dr DiRaimondo has served on the Board of Directors since 1985. A specialist in orthopedic surgery, he graduated from Washington University Medical School in St Louis and served an internship and residency at University Hospital and Clinics. He served on the SMS Physicians Alliance Commission from 1977 to 1990 and is a past president of the Manitowoc County Medical Society.

John E. Kraus, MD
Marinette
Director, District 6
(1989-1992)
Dr Kraus has been a member of the Board of Directors since 1986. A specialist in internal medicine, he graduated from the University of Buffalo School of Medicine. He served an internship in internal medicine at the Millard Fillmore Hospital in Buffalo and residencies in nephrology at Georgetown University Hospital and the Cleveland Clinic.

Philip J. Happe, MD
Eau Claire
Director, District 7
(1991-1994)
A specialist in internal medicine, Dr Happe graduated from Creighton University Medical School in Omaha, Neb, and served an internship at Ancker and St Paul Ramsey hospitals in St Paul, Minn. He completed a residency at Creighton University Affiliated Hospital. He is a past president of the Eau Claire-Dunn-Pepin County Medical Society. Dr Happe was first elected to the Board of Directors in 1985 and serves on the Finance Committee.

Marwood E. Wegner, MD
St Croix Falls
Director, District 7
(1989-1992)
Dr Wegner has been a member of the Board of Directors since 1983. A graduate of the University of Minnesota School of Medicine, he specializes in family practice. He served an internship at the US Public Health Service in Staten Island, NY. Dr Wegner has served on the SMS Committee on Alcoholism and Other Drug Abuse.

Robert L. Sellers, MD
Superior
Director, District 8
(1990-1993)
Dr Sellers graduated from the University of Illinois School of Medicine and is in family practice. He is a member of the SMS Finance and Executive committees. In addition, Dr Sellers is a past president of the Douglas County Medical Society. ❑

Medical Newsletter
On

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SMS commissions, committees and task forces: 1991-1992

THE FOLLOWING is a list of SMS committees, commissions and task forces, and their members for 1991-1992. The original year of each member's appointment, as well as the expiration of his or her term, at the annual meeting of the year designated appears with each member's name. Chairs of commissions and committees are appointed for 1-year terms by the Board of Directors. Vice chairs are elected at the first meeting of each commission and committee following the annual meeting. This issue of the *WMJ* is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

Commissions

Continuing Medical Education

This commission shall consist of up to 20 appointed members and the deans of the two medical schools in Wisconsin, or their designees, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, ie, medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commission on Mediation and Peer Review and the Ad Hoc Committee on Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two groups; and the scientific program of the annual meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

Kathy P. Belgea, MD, Wausau, 1984/1989-1992
Bradley G. Garber, MD, Fairchild, 1989/1989-1992
Warren J. Holtey, MD, Marshfield, 1990/1990-1992
J. David Lewis, MD, West Bend, 1983/1989-1992
Joseph J. Mazza, MD, Marshfield, 1981/1989-1992
L. Cass Terry, MD, Milwaukee, 1990/1990-1992
John W. Beasley, MD, Madison, 1988/1990-1993
Charles E. Holmburg, MD, Menomonee Falls, 1984/1990-1993, vice chair
James M. Lewis, MD, Baraboo, 1991/1991-1993
George Nemec, Jr, MD, Woodruff, 1987/1990-1993
Benson L. Richardson, MD, Green Bay 1984/1990-1993
Walter J. Vallejo, MD, La Crosse, 1988/1990-1993
Edward Zupanc, MD, Monroe, 1986/1990-1993
Harold G. Danford, MD, Appleton, 1991/1991-1994
Charles E. Fenlon, MD, Appleton, 1988/1991-1994
Thomas J. Grau, MD, La Crosse, 1991/1991-1994
Arthur G. Norris, MD, Madison, 1991/1991-1994
Elizabeth T. Sanfelippo, MD, Fond du Lac 1990/1991-1994
Dianne L. Zwicke, MD, Milwaukee 1987/1991-1994, chair

Medical School Deans' designees:
Thomas C. Meyer, MD, UW-Madison
John Fiss, PhD, Medical College of Wisconsin

Staff support: Division of Communications

Mediation and Peer Review

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, and professional ethics. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Frederick W. Blancke, MD, Madison, 1987/1989-1992
Robert T. Cooney, MD, Portage, 1982/1989-1992
John W. Faber, MD, Neenah, 1986/1989-1992
Robert M. Green, MD, La Crosse, 1990/1990-1992
James E. Gutenberger, MD, Madison, 1986/1989-1992
David R. LeCloux, MD, Racine, 1986/1989-1992

Continued on page 342

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Children's Hospital of Wisconsin
Curative Rehabilitation Center
Froedtert Memorial Lutheran Hospital
Medical College of Wisconsin
Milwaukee County Medical Complex
Milwaukee County Mental Health Complex

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Continued from page 340
Lyle L. Olson, MD, Darlington, 1985/1989-1992
Joseph R. Wilczynski, MD, Racine, 1987/1989-1992
Gay R. Anderson, MD, Neenah, 1987/1990-1993
Philip J. Dougherty, MD, Menomonee Falls 1987/1990-1993
Michael J. O'Neill, MD, Green Bay, 1987/1990-1993
David A. Satchell, MD, Manitowoc, 1990/1990-1993
Joseph C. Tiffany, II, MD, Racine, 1990/1990-1993
Santiago L. Yllas, MD, Racine, 1987/1990-1993
Richard C. Zimmerman, MD, Menomonee Falls 1984/1990-1993
Bruce B. Berry, MD, Milwaukee, 1991/1991-1994
Vinoo Cameron, MD, Athens, 1991/1991-1994
William V. Dovenbarger, MD, Marshfield 1985/1991-1994
James P. Long, MD, Beloit, 1987/1991-1994, chair
George A. Pagels, MD, Marshfield, 1988/1991-1994
Dorothy V. Skye, MD, Rhinelander, 1985/1991-1994
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons

Coordinating Council on Physician Impairment
Roland E. Herrington, MD, Wauwatosa (SMS)
Gerald C. Kempthorne, MD, Spring Green (SMS)
Ann Neviaser, Madison, public member (MEB)
Arthur G. Norris, MD, Madison (SMS)
Michael P. Mehr, MD, Marshfield (MEB)
H. Mowat Waldren, Jr, MD, Wauwatosa (MEB)

Managing Committee
Statewide Impaired Physician Program
Pauline M. Jackson, MD, La Crosse
Gerald C. Kempthorne, MD, Spring Green
Fred H. Koenecke, Jr, MD, Madison
Arthur G. Norris, MD, Madison
Wesley E. McNeal, MD, Green Bay
Michael M. Miller, MD, Madison
Marcia J. S. Richards, MD, Milwaukee

Medical Director, SIPP
David G. Benzer, DO, Wauwatosa

Medicaid Medical Audit Committee
R. Marshall Colburn, MD, Oregon
Alfred D. Dally, MD, Madison
John A. DeGiovanni, MD, Prairie du Sac
Philip J. Dougherty, MD, Menomonee Falls
Richard W. Edwards, MD, Richland Center
Charles S. Geiger, Jr, MD, West Bend
John P. Hartwick, MD, Milwaukee
Gerald C. Kempthorne, MD, Spring Green
John J. Kief, MD, Rhinelander
D. Mark Lochner, MD, Waupaca
Bassam M. Rimlawi, MD, Columbus
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons
G. John Weir, Jr, MD, Marshfield

Staff support: Office of Legal Services

Physicians Alliance
This commission shall plan, organize, and implement programs to protect and preserve the legislative, socioeconomic, and political interests of the members of SMS. The commission shall analyze state and federal legislation and administrative rules and policies, and recommend to the Board of Directors specific actions and positions designed to carry out this responsibility. The commission shall also inform the membership of the Society regarding proposed legislation and other public policy initiatives, seek the enactment of legislation for the best interests of the public, scientific medicine, and the medical profession, and promote and encourage Society members to be politically active individually and collectively. This commission shall act to protect the socioeconomic interests of the Society membership in public and private health care delivery systems and recommend to the Board of Directors specific strategies and efforts to achieve this purpose. This commission shall consist of members appointed by the Board of Directors in a number deemed sufficient to execute the responsibilities delegated to the commission. Membership on the commission shall also include a representative from each of the specialty sections of the Society, subject to approval by the Board of Directors. These representatives shall be appointed by the sections annually, and shall have the right to vote on all matters before the commission. The president, president elect, immediate past president, and chair of the Board of the Society shall serve as ex-officio members of the commission with vote.

Carl S. Eisenberg, MD, Milwaukee, 1984/1989-1992, vice chair
Pauline M. Jackson, MD, La Crosse, 1989/1989-1992
Michael J. Kryda, MD, Marshfield, 1989/1989-1992
Larry M. Ojeda, MD, Beloit, 1989/1989-1992
Michael P. Mehr, MD, Marshfield, 1985/1989-1992
Bernard F. Micke, MD, Madison, 1986/1989-1992
Joseph E. Trader, MD, Manitowoc, 1989/1989-1992
Mark H. Andrew, MD, Viroqua, 1990/1990-1993
Steven K. Dankle, MD, Milwaukee, 1990/1990-1993
Vernon N. Dodson, MD, Madison, 1985/1990-1993
Ronald L. Harms, MD, Shawano, 1985/1990-1993
Timothy G. McAvoy, MD, Waukesha, 1987/1990-1993
Robert M. Stern, MD, Milwaukee, 1990/1990-1993

L. Cass Terry, MD, Milwaukee, 1990/1990-1993
DeLore Williams, MD, Elm Grove, 1985/1990-1993
Gregory B. Buck, MD, Wauwatosa, 1990/1991-1994
Randall J. Kieser, MD, Prairie du Chien 1991/1991-1994
Bruce A. Kraus, MD, Columbus, 1988/1991-1994
Michael C. Reineck, MD, West Bend 1984/1991-1994, chair
Charles L. Steidinger, MD, Platteville, 1983/1991-1994
Kevin Hayden, Superior, WMGMA representative
Jeri Cushman, Racine, Auxiliary

President: Cyril M. Hetsko, MD, Madison
President elect: William J. Listwan, MD, West Bend
Immediate past president: Roger L. von Heimburg, MD, Green Bay
Chair of the Board: Richard H. Ulmer, MD, Marshfield

Section representatives
Allergy: Steven L. Kagen, MD, Appleton
Anesthesiology: John F. Kreul, MD, Madison
Dermatology: David K. Falk, MD, Madison
Family physicians: Jack Strong, MD, Mauston
Internal medicine: Susan L. Turney, MD, Marshfield
Neurology: Gamber F. Tegtmeyer, Jr, MD, Madison
Neurosurgery: Mohammed Rafiullah, MD, Racine
Obstetrics-gynecology: Robert K. DeMott, MD, Green Bay
Ophthalmology: Jack L. Hughes, MD, Wauwatosa
Orthopaedic: Robert O. Buss, MD, Elm Grove
Otolaryngology: Richard K. Louden, MD, Sheboygan
Pathology: Roland C. Brown, MD, West Bend
Pediatrics: Ordean L. Torstenson, MD, Madison
Physical medicine and rehabilitation: Donna D. Davidoff, MD, Mequon
Radiation oncology: Howard J. Lewis, MD, Milwaukee

(Other section representatives to be appointed.)

Staff support: Division of Public Affairs and Division of Medical Policy and Practice

Public Information
This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, and develop effective media relations.

Irwin J. Bruhn, MD, Walworth, 1983/1989-1992, chair
Alan H. Cherkasky, MD, Kaukauna, 1983/1989-1992
Timothy T. Flaherty, MD, Neenah, 1986/1989-1992
P. Richard Sholl, MD, Janesville, 1990/1990-1992
Arthur G. Barbier, MD, La Crosse, 1984/1990-1993
Fred J. Bartizal, Jr, MD, Neenah, 1988/1990-1993
Paul D. Nelsen, MD, Green Lake, 1984/1990-1993
Clarence P. Chou, MD, Mequon, 1991/1991-1994
Judith E. Fitzgerald, MD, Madison, 1991/1991-1994
Bradley L. Manning, MD, Madison, 1991/1991-1994
Benjamin C. Wedro, MD, La Crosse, 1987/1991-1994
Don Anderson, medical student, UW
Jean Lawrence, Fond du Lac, Auxiliary

Staff support: Division of Communications

Wisconsin Medical Journal
The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chair and no less than six additional members shall be responsible for all scientific and editorial materials of the *Journal*. An editorial director, serving as chair of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the *Journal*.

Continued on next page

Family Physicians

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Continued from preceding page
Richard D. Sautter, MD, Marshfield, 1990/1991-1992, chair and medical editor
J D Kabler, MD, Madison, 1989/1989-1992
Jeffrey H. Lamont, MD, Wausau, 1989/1989-1992
Richard A. Reinhart, MD, Marshfield, 1989/1989-1992
Susan F. Behrens, MD, Beloit, 1991/1991-1993
Thomas H. Cogbill, MD, La Crosse, 1987/1990-1993
Andrew B. Crummy, Jr, MD, Madison 1985/1991-1994
Donald S. Schuster, MD, Madison, 1991/1991-1994
Victor S. Falk, MD, Edgerton, medical editor emeritus

Editorial associates
(Appointed annually by Board of Directors.)
Kenneth I. Gold, MD, Beloit
Russell F. Lewis, MD, Marshfield
John P. Mullooly, MD, Milwaukee
Richard D. Sautter, MD, Marshfield
John D. Wegenke, MD, Madison

Staff support: Division of Communications

Committees

Aging, Extended Care Facilities, and Home Health Care
This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care and home care.

Kay E. Jewell, MD, Madison, 1982/1989-1992, chair
Bruce A. Kraus, MD, Columbus, 1990/1990-1992
William C. Nietert, MD, Wausau, 1986/1989-1992
Joseph E. Powell, MD, New Richmond 1987/1989-1992
Robert E. Phillips, MD, Marshfield, 1982/1990-1993
Mark A. Sager, MD, Madison, 1990/1990-1993
Thomas H. Williams, MD, Mukwonago 1987/1990-1993
Edward R. Winga, MD, La Crosse, 1982/1990-1993
Steven G. Brown, MD, Menomonie, 1991/1991-1994
Paul E. Hankwitz, MD, Milwaukee, 1985/1991-1994
Richard S. Kane, MD, Milwaukee, 1989/1991-1994
Edward O. Lukasek, MD, Sparta, 1988/1991-1994
Gary A. Schmidt, MD, Manitowoc, 1989/1991-1994
Ronald Menaker, Marshfield, WMGMA representative
Joan Janssen, Mequon, Auxiliary

Staff support: Division of Medical Policy and Practice

Alcoholism and Other Drug Abuse
This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Samuel R. McCreadie, MD, Milwaukee 1986/1989-1992
Thomas H. Peterson, MD, Wausau, 1989/1989-1992, vice chair
Anne M. G. Schierl, MD, Stevens Point 1989/1989-1992
Michael G. Deeken, MD, Wauwatosa, 1990/1990-1993
Thomas P. Koehler, MD, Green Bay, 1991/1991-1993
Fred H. Koenecke, Jr, MD, Madison, 1990/1990-1993
Michael M. Miller, MD, Madison, 1990/1990-1993
Raymond W. Moy, MD, Milwaukee, 1990/1990-1993
David Benzer, DO, Wauwatosa, 1985/1991-1994, chair
John R. Gladieux, MD, Milwaukee, 1988/1991-1994
Brian E. Lochen, MD, Madison, 1991/1991-1994
Edward O. Lukasek, MD, Sparta, 1986/1991-1994
Sherry Stormo, Fond du Lac, Auxiliary

Staff support: Division of Medical Policy and Practice

Environmental and Occupational Health
This committee shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

James L. Basiliere, MD, Oshkosh, 1989/1989-1992
Samuel Idarraga, MD, Marshfield, 1988/1989-1992
Jane Sliwinski, MD, Green Bay, 1990/1990-1992
Sridhar V. Vasudevan, MD, Milwaukee 1989/1989-1992
Carl Zenz, MD, West Allis, 1986/1989-1992
John T. Bolger, MD, Waukesha, 1990/1990-1993
Erwin S. Huston, MD, Milwaukee, 1982/1990-1993
Raymond R. Johnson, MD, Wauwatosa 1984/1990-1993
J. Steven Moore, MD, Brookfield, 1985/1990-1993
Brian D. Wake, MD, Sturgeon Bay, 1990/1990-1993
Charles A. Capasso, MD, Neenah, 1986/1991-1994, chair
Paul F. Durkee, MD, Janesville, 1985/1991-1994 vice chair
Ross S. Myerson, MD, Milwaukee, 1991/1991-1994
James T. Paloucek, MD, Milwaukee, 1985/1991-1994
John J. Ouellette, MD, Madison, 1991/1991-1994
Mark A. Roberts, MD, Milwaukee, 1991/1991-1994
Susan M. Abell, Kenosha, WMGMA representative
Betty Kuplic, Sheboygan, Auxiliary

Staff support: Division of Medical Policy and Practice

Health Care Financing and Delivery Committee
This committee shall be concerned about all aspects of health care financing and delivery systems, including managed health care plans, and shall promote an ongoing dialogue on these issues with business, industry, labor and, when appropriate, government agencies.

Michael J. Brennan, MD, Milwaukee, 1990/1990-1992
Paul G. Harkins, MD, Marshfield, 1990/1990-1992
Stephen D. Hathway, MD, Green Bay 1986/1989-1992
Jerry M. Ingalls, MD, Monroe, 1989/1989-1992
Peter L. Loes, MD, Rhinelander, 1991/1991-1992
Kermit L. Newcomer, MD, La Crosse 1987/1989-1992, chair
Warren H. Williamson, MD, Racine, 1984/1989-1992
Richard A. Ellingstad, MD, Burlington 1988/1988-1993
Kay E. Jewell, MD, Madison, 1990/1990-1993
Russell F. Lewis, MD, Madison, 1982/1990-1993
Rudolf W. Link, MD, Lodi, 1990/1990-1993
William C. Miller, MD, Wausau, 1982/1990-1993
Roger L. von Heimburg, MD, Green Bay 1991/1991-1993
Michael J. Wempe, MD, Kenosha, 1990/1990-1993
Richard H. Christenson, MD, Milwaukee 1986/1991-1994, vice chair
Clyde M. Chumbley, II, MD, Menomonee Falls 1991/1991-1994
Alfred D. Dally, MD, Madison, 1989/1991-1994
Charles S. Geiger, Jr, MD, West Bend 1991/1991-1994
Guenther P. Pohlmann, MD, Milwaukee 1989/1991-1994
Norman J. Schroeder, II, MD, Green Bay 1989/1991-1994
William L. Treacy, MD, Milwaukee, 1991/1991-1994
Joan Albian, Milwaukee, WMGMA representative
Erik Gundersen, medical student, UW

Medical Assistance Technical Advisory Committee (subcommittee)
Richard H. Christenson, MD, Milwaukee, vice chair
Daniel D. Gilman, DO, Milwaukee
Russell F. Lewis, MD, Madison
Wayman Parker, MD, Milwaukee
Guenther P. Pohlmann, MD, Milwaukee
Jack Strong, MD, Mauston
Warren H. Williamson, MD, Racine, chair
Tom Blinn, Madison, Physicians-Plus Medical Group
Kevin Hayden, Superior, Mariner Medical Clinic
Kevin Piper, Madison, DHSS
Alan Ulrich, Neenah, La Salle Clinic

Staff support: Division of Medical Policy and Practice

Maternal and Child Health
This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Stephen C. Caselton, MD, Marinette, 1986/1989-1992
Jerome H. Gundersen, MD, La Crosse 1989/1989-1992
Joanne A. Selkurt, MD, Whitehall, 1981/1989-1992, vice chair
Ordean L. Torstenson, MD, Madison, 1989/1989-1992
Patricia M. Barwig, MD, Milwaukee, 1990/1990-1993
Susan C. Fee, MD, Marshfield, 1991/1991-1993
Robert J. Jaeger, MD, Stevens Point, 1984/1990-1993, chair
Timothy J. O'Neil, MD, Columbus, 1991/1991-1993
Steven D. Stenzel, MD, Eau Claire, 1991/1991-1993
Charles A. Hammond, MD, Neenah, 1985/1991-1994
Perry A. Henderson, MD, Madison, 1985/1991-1994
John E. Inman, MD, Monroe, 1991/1991-1994
Murray L. Katcher, MD, PhD, Madison 1988/1991-1994
John D. Kenny, MD, Madison, 1987/1991-1994
James A. Meyer, MD, Marshfield, 1988/1991-1994
Tom Murwin, medical student, UW
Roberta Baldwin, Watertown, Auxiliary

Study Committee on Maternal Mortality Survey
Everett A. Beguin, MD, La Crosse
Gloria M. Halverson, MD, Waukesha, chair
Perry A. Henderson, MD, Madison
Frederick J. Hofmeister, MD, Wauwatosa
John E. Inman, MD, Monroe
Robert J. Jaeger, MD, Stevens Point
Dan F. Johnson, MD, Eau Claire
Stanley A. Korducki, MD, Milwaukee
Paul R. Meier, MD, Marshfield
Ronald W. Olson, MD, Madison
Bernard B. Poeschel, MD, Eau Claire
Herbert F. Sandmire, MD, Green Bay
Walter R. Schwartz, MD, Wauwatosa
Dorothy V. Skye, MD, Rhinelander
Steven D. Stenzel, MD, Eau Claire
E. Howard Theis, MD, Fond du Lac
Dennis Worthington, MD, Milwaukee
Richard C. Brown, MD, Eau Claire, emeritus

Staff support: Division of Medical Policy and Practice
Continued on next page

Medical Liability
The purpose of this committee shall be to monitor current liability developments and to examine a series of options and alternatives relative to a long-range solution of the medical liability problems, reporting to the Board of Directors.

Joseph C. DiRaimondo, MD, Manitowoc
1990/1990-1992
Charles F. Dungar, MD, Appleton, 1987/1989-1992
C. Robert Jackson, MD, Madison, 1987/1989-1992
Sidney E. Johnson, MD, Marshfield, 1987/1989-1992
Steven L. Lawrence, MD, Milwaukee, 1989/1989-1992
Richard G. Roberts, MD, Madison
1987/1989-1992, vice chair
Bruce B. Berry, MD, Milwaukee, 1989/1990-1993
Jerome W. Fons, Jr, MD, Greenfield, 1989/1990-1993
William J. Listwan, MD, West Bend, 1987/1990-1993
Herbert F. Sandmire, MD, Green Bay
1987/1990-1993
Robert S. Witte, MD, La Crosse, 1991/1991-1993
S. Marshall Cushman, Jr, MD, Racine
1988/1991-1994
Lucille B. Glicklich, MD, Milwaukee, 1987/1991-1994
Thomas M. Kidder, MD, Milwaukee, 1987/1991-1994, chair
Michael C. Reineck, MD, West Bend, 1987/1991-1994
W. Stuart Sykes, MD, Madison, 1987/1991-1994
Luther M. Strayer, III, MD, Neenah, 1989/1991-1994
Alice Soule, Madison, WMGMA representative
Jackie Dungar, Appleton, Auxiliary

Staff support: Division of Medical Policy and Practice

Medicine, Religion and Ethics
This committee shall be concerned about the medical and spiritual values of health care, the bioethical aspects of medical practice, and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients, and to clarify the relationship between ethics and science in medicine.

David J. Deubler, MD, Kiel, 1989/1989-1992
John W. Faber, MD, Neenah, 1982/1989-1992
Nancy K. France, MD, Milwaukee, 1990/1990-1992
David J. Matteucci, MD, Kenosha, 1989/1989-1992
G. Daniel Miller, MD, Dousman, 1982/1989-1992
Richard J. Thurrell, MD, Madison, 1990/1990-1992
James E. Glasser, MD, La Crosse, 1987/1990-1993
John C. Jordan, MD, Richland Center, 1985/1990-1993
Charles L. Junkerman, MD, Milwaukee
1990/1990-1993, chair
J D Kabler, MD, Madison, 1990/1990-1993
John P. Mullooly, MD, Milwaukee, 1989/1990-1993
Philip H. Utz, MD, La Crosse, 1987/1990-1993
Philip J. Dougherty, MD, Menomonee Falls
1991/1991-1994
Scott S. Erickson, MD, Marshfield, 1987/1991-1994
John K. Scott, MD, Madison, 1990/1991-1994
Rodney Sorensen, DO, Marshfield, 1987/1991-1994
William G. Weber, MD, Oshkosh, 1991/1991-1994
Diana L. Wright, MD, Beloit, 1991/1991-1994
James F. Zimmer, MD, Hales Corners
1991/1991-1994
Miep Kempthorne, Spring Green, Auxiliary

Staff support: Division of Medical Policy and Practice

Membership (ad hoc)
This committee shall function as a sounding board for programs, plans, and strategies to address expansion of SMS membership, as well as to evaluate membership campaigns and existing SMS programs. It reports to the Board of Directors.

Mark H. Andrew, MD, Viroqua
Timothy T. Flaherty, MD, Neenah, chair
Richard D. Fritz, MD, Milwaukee
Carlos A. Jaramillo, MD, Monroe
Harry J. Zemel, MD, Fond du Lac
John A. Nemec, La Crosse, WMGMA representative

Mental Health
This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

Peter L. Eichman, MD, Madison, 1982/1989-1992
Pauline M. Jackson, MD, La Crosse, 1989/1989-1992
Rudolf W. Link, MD, Madison, 1983/1989-1992, chair
Margaret J. Seay, MD, Oshkosh, 1985/1989-1992
Laurens D. Young, MD, Milwaukee
1987/1989-1992, vice chair
Robert E. O'Connor, MD, Madison, 1990/1990-1993
Leonard J. Ganser, MD, Madison, 1991/1991-1993
Robert B. Shapiro, MD, Madison, 1983/1990-1993
Donald L. Feinsilver, MD, Milwaukee
1985/1991-1994
James F. Land, MD, Madison, 1991/1991-1994
Wess R. Vogt, MD, Mequon, 1985/1991-1994
Pixie Litt, Green Bay, WMGMA representative
Katie Webster, La Crosse, Auxiliary

Staff support: Division of Medical Policy and Practice

Continued on page 348

AIM HIGH

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AIR FORCE

Continued from page 346

Safe Transportation
This committee shall be concerned with the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air. This includes the responsibility to review the emergency medical systems in Wisconsin that serve the needs of those injured in transportation accidents.

John C. Heffelfinger, MD, Nekoosa, 1983/1989-1992
Richard D. Lindgren, MD, Madison, 1986/1989-1992
Thomas J. Luetzow, MD, Larsen, 1986/1989-1992
Thomas H. Cogbill, MD, La Crosse, 1991/1991-1993
Ralph F. Hudson, MD, Eau Claire, 1989/1990-1993
Kathryn P. Nichol, MD, Madison, 1982/1990-1993
Stephen W. Hargarten, MD, Milwaukee
1985/1991-1994, chair
Susan Kinast-Porter, MD, Monroe, 1985/1991-1994
Raymond E. Skupniewicz, MD, Racine
1990/1991-1994
Sherri Bush, Beaver Dam, Auxiliary

Staff support: Division of Medical Policy and Practice

School Health
This committee shall be concerned about maintaining and improving the health of those attending the public or private schools of this state, including matters related to athletics.

Roy E. Buck, MD, Oshkosh, 1983/1989-1992
Natalie L. Gehringer, MD, Menasha, 1986/1989-1992
Patricio F. Viernes, MD, Brookfield, 1987/1989-1992
Victoria A. Vollrath, MD, Madison, 1989/1989-1992
Paul F. Dvorak, MD, Madison, 1990/1990-1993
Jeffrey H. Lamont, MD, Wausau, 1987/1990-1993, chair
Rolf L. Simonson, MD, Sheboygan, 1982/1990-1993
James S. Janowiak, MD, Merrill, 1985/1991-1994
Charles H. Miller, III, MD, La Crosse, 1988/1991-1994
Louis J. Ptacek, MD, Marshfield, 1988/1991-1994
Mary Smigielski, Milwaukee, Auxiliary
Sherry Stormo, Fond du Lac, Auxiliary

WIAA Medical Advisory Committee
Conrad L. Andringa, MD, Madison, chair
Phillips T. Bland, MD, Westby
James H. DeWeerd, Jr, MD, Stevens Point
Frederick W. Gissal, MD, Wisconsin Dells
Ronald L. Harms, MD, Shawano
Rolf S. Lulloff, MD, Green Bay
Kermit L. Newcomer, MD, La Crosse
John K. Scott, MD, Madison
Elizabeth A. Steffen, MD, Racine

Staff support: Division of Medical Policy and Practice

WNA-SMS Liaison
In 1987 the Nurse Physician Liaison Committee was renamed the WNA-SMS Liaison Committee. This committee shall be concerned with developing recommendations, as appropriate, regarding education, legislation, practice arrangements and delivery patterns; facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles and practices; and serve as a consultation resource in matters that relate to joint practice.

SMS members:
Robert T. Cooney, MD, Portage, 1987/1989-1992
Marc F. Hansen, MD, Madison, 1987/1989-1992
Albert J. Motzel Jr, MD, Waukesha, 1987/1990-1993, co-chair
Sandra L. Osborn, MD, Madison, 1990/1990-1993
Carl S. Eisenberg, MD, Milwaukee, 1987/1991-1994

WNA members:
Susan Bulgrin, RN, Portage
Judy Ellington, RN, Baraboo, co-chair
Norma Lang, RN, PhD, Milwaukee
Sherry Quamme, RN, Columbus
Leona VandeVusse, RN, Milwaukee

Staff support: Office of Legal Services

Task forces

Task Force on AIDS
In 1987, the Board of Directors established this task force to advise members of the SMS on the formulation of public policy to address the scientific, medical, ethical, legal, and legislative issues pertaining to AIDS.

SMS members:
Patricia M. Barwig, MD, Milwaukee
John F. Cooper, MD, Madison
Gerald J. Dorff, MD, Milwaukee
John F. Doyle, DDS, Madison
Charles E. Gessert, MD, Milwaukee
Ian H. Gilson, MD, Milwaukee
Jerome H. Gundersen, MD, La Crosse
Cyril M. Hetsko, MD, Madison, chair
Stanley L. Inhorn, MD, Madison
Charles L. Junkerman, MD, Milwaukee
J. Douglas Lee, MD, Marshfield
Edwin L. Overholt, MD, La Crosse
Richard M. Reich, MD, Madison
Michael W. Rytel, MD, Milwaukee
Thomas L. Schlenker, MD, Milwaukee
Jeffrey E. Taxman, MD, Milwaukeke

Louise Scott, Madison, Auxiliary

WHA member:
Jane Olson, WHA, Madison
Special advisory members:
Jeffrey P. Davis, MD, Madison
James M. Vergeront, MD, Madison

Staff support: Office of Legal Services

Blue Ribbon Task Force on Alternatives to the Tort System

In 1987, the Board of Directors established the Blue Ribbon Task Force on Alternatives to the Tort System to evaluate possible alternative dispute resolution systems to replace the current medical liability tort system. Systems to be considered include fault-based administrative systems, no-fault compensation systems, and arbitration and contractual arrangement systems. Pending review of the task force's findings by the SMS Board and House of Delegates, a model alternative may be presented to the Wisconsin legislature for possible enactment.

C. Robert Jackson, MD, Madison
William J. Listwan, MD, West Bend
John P. Mullooly, MD, Milwaukee
Richard G. Roberts, MD, Madison
John O. Simenstad, MD, Osceola
William L. Treacy, MD, Milwaukee
Darold A. Treffert, MD, Fond du Lac
Roger L. von Heimburg, MD, Green Bay, chair
Thomas L. Adams, Madison, SMS
Gordon Baldwin, Madison, University of Wisconsin
Steve Dickmann, Stoughton, Nelson Industries
John Duncan, Milwaukee, Metropolitan Milwaukee Association of Commerce
Insurance Commissioner Robert Haase, Madison
John Parr, Milwaukee, AFCME Council
State Rep Peggy Rosenzweig, Wauwatosa

Staff support: Division of Medical Policy and Practice

Physician Review and Discipline

The purpose of this task force shall be to evaluate and make recommendations for the improvement of physician review and discipline in Wisconsin.

William L. Baker, MD, Monroe

Continued on next page

Peppino's

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Continued from preceding page
Susan F. Behrens, MD, Beloit
Barry Blackwell, MD, Milwaukee
Peter L. Eichman, MD, Madison, chair
Timothy T. Flaherty, MD, Neenah
C. William Freeby, MD, Appleton
Richard D. Fritz, MD, Milwaukee
Charles S. Geiger, Jr, MD, West Bend
Lucille B. Glicklich, MD, Milwaukee
Cyril M. Hetsko, MD, Madison
Robert E. Johnston, MD, Green Bay
J D Kabler, MD, Madison
Gerald C. Kempthorne, MD, Spring Green
Russell F. Lewis, MD, Madison
Rudolf W. Link, MD, Lodi
D. Mark Lochner, MD, Waupaca
James P. Long, MD, Beloit
Philip H. Utz, MD, La Crosse
Otto Cox, Appleton, St. Elizabeth's Hospital

Staff support: Office of Legal Services

Task Force on Relationships Between Medical Schools and the Medical Community in Wisconsin
The purpose of this task force shall be to develop a set of principles that would guide the communication and interactions between the private medical community and the medical schools as they pursue their educational mission. These principles should be developed in consultation with the medical schools and private medical community and should address the potential for conflict and ways to facilitate the resolution of conflicts that arise.

T. Michael Bolger, President, Medical College of Wisconsin, Milwaukee
Arnold L. Brown, MD, Dean, UW Medical School, Madison
J. Timothy Harrington, MD, Madison
Albert J. Motzel, Jr, MD, Waukesha, chair
Marcia J.S. Richards, MD, Milwaukee

Staff support: Division of General Administration

SMS/WHA Joint Task Force on the Patients Compensation Fund
This SMS/WHA joint task force shall review the function and operation of the state Patients Compensation Fund and make recommendations to their respective boards on all PCF activities by January 1992.

SMS members:
Geoffrey K. Bowman, MD, Fort Atkinson
Bruce C. Bressler, MD, Green Bay
Jan E. Erlandson, MD, Monroe
Sidney E. Johnson, MD, Marshfield
Eugene P. Sinclair, MD, Elm Grove

Staff support: Division of Medical Policy and Practice

Committees of the Board

Executive
Cyril M. Hetsko, MD, Madison, chair
president of the Society
William J. Listwan, MD, West Bend
president elect of the Society
Roger L. von Heimburg, MD, Green Bay
immediate past president of the Society
Richard H. Ulmer, MD, Marshfield
chair of the Board
Raymond C. Zastrow, MD, Milwaukee
vice chair of the Board
Harry J. Zemel, MD, Fond du Lac
chair, Finance Committee
Richard G. Roberts, MD, Madison
speaker of the House of Delegates
Robert F. Purtell, Jr, MD, Milwaukee
director at large
Robert L. Sellers, MD, Superior
director at large
Ex Officio non-voting members:
Sandra Kontra, Racine
Auxiliary president
Fe Abellera, Onalaska
Auxiliary president elect

Finance
Harry J. Zemel, MD, Fond du Lac, chair
Philip J. Happe, MD, Eau Claire
Jack M. Lockhart, MD, La Crosse
Thomas A. Reminga, MD, Milwaukee
Robert L. Sellers, MD, Superior
Raymond C. Zastrow, MD, Milwaukee ❑

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Expense reimbursement policy and procedure for physicians on SMS business

IT IS SMS POLICY to offer reimbursement of out-of-pocket expenses incurred by its officers, directors, committee chairs and members, AMA delegates and alternates and other designated physicians when such expenses are incurred in the course of the conduct of business on behalf of the Society. The Society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. Traditionally, this has been accepted as a contribution to the profession and the health of the public. Out-of-pocket expenses in the discharge of official functions of the Society are, however, reimbursable as set forth below, except that district directors are not reimbursed for the expense of attending the annual meeting of the Society (Bylaws, Chapter V, Sec 4).

Officers, directors, committee chairs and members, and other designated persons

Reimbursable expenses include the cost of:

- All meals, including normal tips, incurred while away from the physician's home city on SMS business.
- All meals in the home city of the physician when these are in relation to an SMS business meeting.
- Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the Society.
- Valet and laundry services when the physician is away from home city on SMS business continuously for four days or more.
- Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
- Transportation from home city to meeting site and return as follows:

Air. Cost of round trip coach airfare, plus necessary ground transportation.
Bus or train. Cost of round trip fare, plus necessary ground transportation.
Auto. Mileage at the current Society rate (now $.275) to and from the meeting site, plus necessary parking fees and highway tolls.
Miscellaneous ground transportation. Local bus and cab fares as necessary.
Auto rental. All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel.

- Telephone, fax and telegraph communications relative to SMS business.
- Secretarial and copying services, postage and stationary used for SMS business. (Note: SMS headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. Physicians may be reimbursed, however, for personal or office costs relating to secretarial, copying, postage and stationery used in conducting SMS business. Copies of all official correspondence should be sent to the appropriate committee staff person at SMS, so as to assure proper coordination and record-keeping.
- Expenses, as described above, incurred by the president/president elect's spouses when accompanying in an official capacity, or when the spouse is expected to be in attendance, are reimbursable.

Procedure for claiming expenses. To obtain reimbursement, submit a statement of expenses incurred. Attach copies of bills or receipts for all lodging, travel, and meals over $25. Itemize separately costs for the eighth item above. Mail to SMS Business Services and Support, PO Box 1109, Madison, WI 53701. Reimbursement will be made within two weeks following receipt and approval of the expense report.

AMA delegates and alternates

AMA delegates and alternates (including the young physicians delegate and alternate) from Wisconsin receive reimbursement as follows for each meeting to the AMA House of Delegates they attend:

- Round trip economy air fare (advance booking strongly suggested.)
- Actual cost of room (mid-range) for five nights at the Annual Meeting, and four nights at the Interim Meeting.
- A per diem (currently $60) for food and all incidentals for six days at the Annual Meeting, and five days at the Interim Meeting.
- When AMA delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for officers and directors.

Out-of-state trips

With the exception of travel to the AMA House of Delegates meetings and travel of the SMS president and president elect, all out-of-state trips must have prior approval by the Executive Committee to be reimbursable. Contact the secretary and general manager. ▫

SMS financial report

The following financial statements of the State Medical Society of Wisconsin are part of the treasurer's report to the House of Delegates. The annual certified audit, prepared by Grant Thornton, independent certified public accountants, is on file at Society headquarters. Members may review the audit by inquiry to the SMS secretary-general manager.

SMS general fund balance sheet

Dec 31, 1990

Assets	
Current assets	
Cash and cash equivalents	$ 3,700,486
Investments	870,109
Accounts receivable	
Trade	77,384
Due from affiliates	88,623
Investment revenues receivable	10,444
Inventories	5,769
Prepaid expenses	47,095
Total current assets	$ 4,799,910
Property and equipment–at cost	
Building and equipment	$ 2,488,991
Furniture and equipment	1,134,535
Capitalized Lease Equipment	225,820
Less accumulated depreciation	(1,223,859)
Land	52,875
Total property and equipment	$ 2,678,382
Other assets	
Rental property, net of accumulated depreciation of $58,042	$ 1,396,708
Prepaid pension costs	369,549
Long-term investment	249,000
Cash value of life insurance	2,231
Investment in subsidiary	454,271
Deferred compensation plan assets	119,746
Notes Receivable	100,000
Total other assets	$ 2,691,505
Total assets	$10,169,797
Liabilities	
Current liabilities	
Current maturities of long-term debt	$ 103,234
Trade accounts payable	104,489
Dues payable to other organizations	1,415,054
Accrued payroll and vacation pay	141,234
Accrued property, payroll and sales taxes	161,760
Deferred revenues	2,428,399
Other	16,529
Total current liabilities	$ 4,370,699
Long-term debt less current maturities	$ 2,628,473
Deferred compensation payable	$ 120,691
Membership equity	$ 3,049,934
Total liabilities and membership equity	$10,169,797

Statement of income and expense

Year ended Dec 31, 1990

Income	
Membership dues	$ 2,659,169
Sales and services	820,930
Investment income	166,321
Royalty income	344,098
Gain on sale of investments	19,755
Loss on disposal of property and equipment	(685)
Rental	279,317
Pension benefit	17,668
AIDS regional education and training center grant	161,980
Other	47,266
Total income	$ 4,515,819
Expenses	
Payroll and employee benefits	$ 2,037,670
Travel and conference	542,217
General and administrative	644,677
Occupancy	561,635
Professional fees and outside services	303,747
AIDS regional education and training center grant	161,736
Interest expense	266,156
Total expenses	$ 4,517,838
Excess of expenses over revenues	($ 2,019)
Equity at Jan 1, 1990	$ 3,009,041
Equity in earnings of subsidiary	$ 42,912
Equity at Dec 31, 1990	$ 3,049,934

SMS placement service aids physicians and communities

ONE OF THE MANY FUNCTIONS of the SMS is to assist physicians who are seeking a location to practice in Wisconsin, and to assist communities seeking the services of physicians.

The Society's placement service maintains a list of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, the AMA, and Wisconsin's medical schools. There is no charge for this service.

A list of openings is sent to physicians who contact the placement service, indicating a desire to move to Wisconsin or to relocate within the state. A list of physicians is sent to communities requesting assistance in obtaining a physician. The physicians and communities may then contact one another. Physicians seeking associates also may request a list of available physicians.

Experience shows that physicians seek locations on a long-range basis--some are available at once, while others are in residency for 2 or 3 years. Please advise the placement service of your needs as soon as possible. Overnight results sometimes occur, but more time usually means better results.

It should be noted that the placement service is not in the business of recruiting. It is supported by the membership of the SMS. The Society does, however, cooperate with the state-supported Office of Rural Health in its New Physicians for Wisconsin Program, which provides placement services to communities and physicians on a fee basis determined by budgetary funds available.

Physicians and communities may also use the medical yellow pages section of the *Wisconsin Medical Journal.* This classified advertising section is available to SMS members, other physicians, communities, clinics, hospitals, recruitment firms, and others, at reasonable rates.

Physicians using the placement service have described it as one of the most effective in the United States. *WMJ* advertising, too, has proved highly successful.

Inquiries should be addressed to: Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701; 608-257-6781 or toll-free, 1-800-362-9080; FAX 608-283-5401; or to the *Wisconsin Medical Journal*, Box 1109, Madison, WI 53701. ▫

SMS President Cyril M. "Kim" Hetsko, MD, (l) congratulates his predecessor, Roger L. von Heimburg, MD, (r) on receipt of the Past President's Award.

Charter law of the SMS

Chapter 148

148.01(1) State society. The State Medical Society of Wisconsin is continued with the general powers of a corporation. It may, from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02(1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists, may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

Note on §148.03, 447.13, 449.15 and 450.13: Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ▫

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NOTE: New Format forms expected for introduction late 1991.

Place your order with SMS Holdings Corp, PO Box 1109, Madison, WI 53701; or phone 608-257-6781 or toll-free in Wisconsin 800-545-0632, FAX 608-283-5401.

SMS Constitution and Bylaws

Constitution

Article I
Name of the association

The name and title of this organization shall be the State Medical Society of Wisconsin.

Article II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution and Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

Article III
Component societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

Article IV
Composition of the association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided in the Bylaws.

Article V
House of Delegates

The House of Delegates shall be the legislative body of the Society and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote.

The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty society.

Article VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum. Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district. In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and, as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end membership totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the secretary before annual elections to the Board. As nearly as possible, one-third of the members of the Board shall be elected each year. Each director shall be nominated and elected only by the elected delegates of the county medical society of societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates. The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

Adopted as amended by the House of Delegates, April 26-27, 1990.

Article VII
Specialty sections

The House of Delegates shall provide for a division of the Society into specialty sections.

Article VIII
Meetings

Section 1. The Society shall hold an annual meeting, at which time the House of Delegates shall meet to conduct its business. The annual meeting may also include scientific sessions as determined by the Board.

Sec 2. The place for holding each annual meeting shall be fixed by the House of Delegates, or by failure to act, such authority is delegated to the Board. The time and the place for holding each annual meeting shall be approved by the Board.

Sec 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

Article IX
Officers

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The secretary shall be elected annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect. The treasurer shall be limited to nine consecutive terms. No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

Article X
Funds and expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class. All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

Article XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

Article XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous annual meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

Bylaws

Chapter 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be prima facie evidence of membership and of the right to benefits.

Sec 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its

members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec 5. A member of a component society whose license has been revoked, suspended, non-renewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, non-renewal, or voluntary surrender, pending definitive action by the Board.

Sec 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec 9. Membership classifications. Members defined in this section, except affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B.(5), may upon application, recommendation by the county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective

January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec 10. Dues and Assessments. Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* dues and assessments are to be determined by the Board of Directors. Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

Chapter II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society. For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled. The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec 3. The speaker shall preside at the meetings of the House of Delegates.

Sec 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

Chapter III
Annual election

Section 1. The House of Delegates, at its first session of the annual meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional

five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. Nominating committee members shall be limited to nine (9) consecutive terms. Those committee members who have served nine (9) consecutive terms upon adjournment of the final session of the 1993 House of Delegates annual meeting and following years shall have met this requirement. This committee shall become operative at the close of the final session of that annual meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the annual meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates. The Committee on Nominations shall convene at least two (2) months prior to the annual meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the annual meeting.

Sec 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Chapter IV
Duties of officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. deliver an annual address to the House;
b. serve as a member with right to vote on the Board;
c. preside at meetings of the Executive Committee of the Board;
d. participate, ex officio and without the right to vote, in sessions of the House;
e. initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. support and articulate policies and programs adopted by the Board and the House.
g. promote physician interest and active participation in the Society.

Sec 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec 4. The Secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. The Secretary shall serve as an ex officio, nonvoting member of the Board; be responsible to the Board and serve as its secretary; assist the Board and officers in making decisions and implementing actions; share convictions and argue their merits; perform the functions ordinarily assigned to the office of Secretary, and make an annual report to the House of Dele-

gates. "As chief executive officer the secretary shall, within the limits of the Constitution and Bylaws and Board operating policies, effectively perform the general managerial function for the Society and all of its divisions, activities, and personnel including employment and, as necessary, termination of all employees; be responsible for and have the necessary authority to direct, supervise, and coordinate all programs, projects and major activities of the Society and all wholly owned subsidiaries; formulate and recommend for approval of the Board basic policies and programs which will seek to achieve the objectives and goals of the Society; fully inform the Board on the condition and operation of the association; cooperate with the Board and Treasurer in establishing a program of fiscal responsibility for the Society including development, recommendation and upon approval, operation within an annual budget; act to insure that all funds, physical assets, and other property of the Society are appropriately safeguarded and administered; develop and maintain effective internal and external communications with the membership and other organizations and agencies, both public and private, so as to enhance the positions of the Society and the objectives of its membership; and through effective management and leadership, achieve economic, productive performance, forward-looking programming, and constructive growth of the Society."

Note: Following adoption of this Bylaw change (Sec. 4 above) in 1987, the Board agreed to develop and maintain a set of current "operating policies" between itself and the secretary to detail the more specific duties and expectations important to a good working relationship between the Board and the secretary.

Chapter V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec 2. The Board shall meet during the annual meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the House of Delegates including all major actions and policy decisions of the preceding year.

Sec 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the annual meeting of the Society.

Sec 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board. The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions. The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are

in conflict with the letter or spirit of this Constitution and Bylaws.

Sec 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified. When a district initially qualified for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec 12. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

Chapter VI
Commissions and committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office. Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

Chapter VII
Dues and assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the secretary on or before the dues payment deadline, as established by the Board of Directors, shall be deemed in arrears and shall be removed from the membership rolls of the county society and this Society until such time as full dues for the current year have been received.

Sec 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of Delegates and to any other benefits and privileges of membership.

Chapter VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

Comment: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

Chapter IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

Chapter X
County societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon applica-

tion to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec 2. Only one component medical society shall be chartered in each county.

Sec 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec 5. The secretary of each county society shall keep a roster of its members.

Chapter XI
Specialty sections

Section 1. The House of Delegates shall establish specialty and special sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established using the following guidelines:

a. For specialty section to be designated it must represent a specialty which is represented in the American Medical Association House of Delegates and
b. Have at least twenty (20) members of the specialty who are members of this Society.
c. If no representative from the specialty section registers as a representative of that section for three (3) consecutive annual meetings, the specialty section will be dropped with the option of reapplying after one year, provided the above criteria are met.
d. From time to time special sections not meeting the above criteria may be established by the House of Delegates.

Sec 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors, Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

Chapter XII
Amendments

These Bylaws may be amended at any annual meeting by a majority vote of the delegates present, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one session of that annual meeting.❑

Officers of Wisconsin's county medical societies

Key: president (P), co-president (CP), president elect (PE), vice president (VP), secretary (S), treasurer (T), executive secretary (ES), executive vice president (EVP), executive director (ED), executive assistant (EA), assistant secretary (AS).

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715-483-3221
S–James S. Moore, Jr, MD
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715-483-9875

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P–Edwin G. May, MD
2501 Main St
Stevens Point 54481
715-344-4120
S–Joseph F. Jarabek. MD
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Stevens Point 54481
715-344-4120

Price-Taylor
P–Michael A. Haase, MD
101 N Gibson Ave
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715-748-2121
S–Walther W. Meyer, MD
612 E Perkins St
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715-748-2121

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414-633-8245
PE–Carol W. Potts, MD
2405 Northwestern Ave
Racine 53404
414-632-7521
S – Kenneth A. Klein, MD
5351 Short Rd
Racine 53402-9776
T–Peter J. Bartzen, Jr, MD
PO Box 085001
Racine 53408-5001
414-631-8204
ES–John Bjelajac
PO Box 592
Racine 53401-0592
414-634-0702

Continued on next page

Continued from preceding page

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608-647-6161
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Beloit 53511
608-364-2240
VP–David C. Murdy, MD
580 N Washington
Janesville 53545
608-755-3500
S–Larry M. Ojeda, MD
1905 Huebbe Parkway
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608-364-2200

Rusk
P–Ron M. Charipar, MD
1216 E River
Ladysmith 54848
715-532-6615
S—Rebecca J. Allen, MD
906 W College Ave
Ladysmith 54848
715-532-6651

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Baraboo 53913
608-356-6656
S – Vacant

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S–Paul Strapon, III, MD
PO Box 764
Hayward 54843
715-634-8911

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P–Ralph D. Petty, MD
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Shawano 54166
715-524-2161
S–Kevin J. Weber, MD
117 E Green Bay St
Shawano 54166
715-524-2161

Sheboygan
P–John P. Hermann, MD
2414 Kohler Memorial Dr
Sheboygan 53081
414-457-4461
S–Dennis A. Wood, MD
2629 N Seventh St
Sheboygan 53083

Trempealeau-Jackson-Buffalo
P–K. Roger Gilbert, MD
Rt 1, Box 329
Blair 54616
608-989-2167
S–Geoffrey C. Kloster, MD
219 S Main St
Galesville 54630
608-582-2286

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P–Mark H. Andrew, MD
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VP–Timothy J. Devitt, MD
RFD 1
Soldiers Grove 54655
S–Rolando A. Macasaet, MD
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PO Box 710
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414-248-8527

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P–Uday V. Gupte, MD
1004 E Sumner St
Hartford 53027
414-673-5050
PE – Jeffrey C. Koszczuk, DO
205 Valley Ave
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414-338-1123
S – Peter L. Cornelius, MD
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PE–Kraig E. Lorenzen, MD
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414-784-7150
T–Ronald Martins, MD
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ES–Robert Herzog
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S–Donn D. Fuhrmann, MD
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Winnebago
P–Gerald A. Gehl, MD
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Neenah 54956
414-725-8285

PE – William G. Weber, MD
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Oshkosh 54901
414-233-4270
S–James E. Cauley, MD
400 Ceape Ave
Oshkosh 54901
414-236-3238

Wood
P–Theodore A. Praxel, MD
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Wisconsin Rapids 54494
715-423-0122
VP – Robert E. Phillips, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5852
S–Louis C. Hacker, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5457 ❑

Officers of the SMS special sections

As of June 1, 1991

Key: chair (C), chair elect (CE), vice chair (VC), secretary-treasurer (ST), delegate (D), alternate delegate (AD), AMA delegate (AMA D), AMA alternate delegate (AMA AD). Expiration of term appears in parentheses.

Allergy and Clinical Immunology
(November 1991)
C–Marshall E. Cusic, MD
1000 N Oak Ave
Marshfield 54449
D–Steven H. Cohen, MD
5020 W Oklahoma Ave
Milwaukee 53219
414-546-1110
AD–Robert J. Kriz, MD
1 S Park St
Madison 53715

Anesthesiology
(September 1991)
C–Warren J. Holtey, MD
Marshfield Clinic
1000 N Oak Ave
Marshfield 54449
ST–W. Stuart Sykes, MD
1005 Columbia Rd
Madison 53705
608-233-4486
D–Warren J. Holtey, MD
AD–Gregory A. Felsheim
18920 Alta Vista Dr
Brookfield 53005

Cardiology
D–A. Daniel Harbin, MD
1836 South Ave
La Crosse 54601
608-782-7300

Dermatology
(October 1991)
C–Michael J. Smullen, MD
1239 W Mason St
Green Bay 54304
414-499-0696
CE–David Falk, MD
1313 Fish Hatchery Rd
Madison 53715
608-252-8101
ST–William P. LeFeber, MD
324 E Wisconsin Ave
Milwaukee 53202
414-271-2721
D–Joel E. Taxman, MD
1622 W Wisconsin Ave
Milwaukee 53233
414-933-2552
AD–Nyles R. Eskritt, MD
3508 E Maria Dr
Stevens Point 54481

Emergency Medicine
(April 1992)
C–Mark J. Mirick, MD
333 Pine Ridge Blvd
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715-847-2160

ST–John J. Maher, MD
1969 W Hart Rd
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608-364-5682
D–Premal M. Joshipura, MD
1609 Virginia
Libertyville, IL 60048

Family Physicians
(June 1991)
C–Terry L. Hankey, MD
900 Riverside Dr
Waupaca 54981
715-258-0200
D–Terry L. Hankey, MD
AD–Thomas H. Peterson, MD
995 Campus Dr
Wausau 54401
715-675-3391

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C–John J. Beck, MD
345 S 18th Ave
Sturgeon Bay 54235
414-743-7261
D–Stephen R. Peters, MD
17780 Mierow Ct
Brookfield 53005
414-257-6269
AD–Louis R. Pfeiffer, MD
515 Prospect Ave
Nekoosa 54457
AMA D–Edward R. Winga, MD
1836 South Ave
La Crosse 54601
608-782-7300

Continued on next page

Continued from preceding page

Internal Medicine
(September 1991)
C–Robert E. Phillips, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5852
S–Bruce A. Polender, MD
1836 South Ave
La Crosse 54601
608-782-7300
D–Susan L. Turney, MD
1000 N Oak Ave
Marshfield 54449
715-387-5435
AD–Richard A. Dart, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5345

International Medical Graduates
(Will be organized during 1991)

Medical Faculties
AD–Manucher J. Javid, MD
H4/346 UW CSC
600 Highland Ave
Madison 53792
608-263-1410

Medical Students
C–Donald J. Anderson
6810 Schroeder Rd, #2
Madison 53711
608-273-4103
C–Katherine M. Hegmann
1825 Parkside Ave, Apt. E1
Park Ridge, IL 60068-1047
D–M. Zuhdi Jasser
1244 N 68th St, #206
Wauwatosa 53213
414-258-7349
AD–Donald J. Anderson
6810 Schroeder Rd, #2
Madison 53711

Neurology
(October 1991)
C–Robert T. Schmidt, Jr, MD
1325 S Summer Range Rd
De Pere 54115
D–Gamber F. Tegtmeyer, Jr, MD
20 S Park St, Suite 202
Madison 53715
608-255-4826

Neurosurgery
(October 1991)
D–Glenn A. Meyer, MD
16475 Shoreline Dr
Brookfield 53005
414-257-6465
AD–S. Marshall Cushman, Jr, MD
3831 Lighthouse Dr
Racine 53402
414-637-6106

Obstetrics-Gynecology
(July 1992)
C–Paul G. Harkins, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5206
ST–Everett A. Beguin, Jr, MD
1836 South Ave
La Crosse 54601
608-782-7300
D–Charles A. Hammond, MD
411 Lincoln St
Neenah 54956
414-727-4304
AD–Michael A. Schellpfeffer, MD
1400 75th St
Kenosha 53140
414-658-2133

Ophthalmology
(September 1992)
C–Peter J. McCanna, MD
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Madison 53715
608-258-4520
ST–Jack L. Hughes, MD
2500 N Mayfair Rd, Suite 200
Wauwatosa 53226
414-259-1930
D–M. Thomas Chemotti, MD
N69 W5289 Columbia Rd
PO Box 503
Cedarburg 53012-0503
414-377-8118
AD–Gregory P. Kwasny, MD
2300 N Mayfair Rd, Suite 1030
Wauwatosa 53226

Orthopaedics
(May 1992)
C–Joseph C. DiRaimondo, MD
1636 Miriam Rd
Manitowoc 54220
414-682-6376
ST–William R. Niedermeier, MD
2 W Gorham St
Madison 53703
608-255-9414
PE–Paul A. Jacobs, MD
1218 W Kilbourn Ave
Milwaukee 53233
414-276-6000
D–James A. Rydlewicz, MD
5233 W Morgan Ave
Milwaukee 53220
414-771-5080
AD–James H. Langenkamp, MD
2040 Wisconsin Ave
Milwaukee 53233
414-933-8158

Otolaryngology
(April 1992)
P–Steven L. Overholt, MD
1836 South Ave
La Crosse 54601
608-782-7300
PE–Steven Millen, MD
11035 W Forest Home Ave
Hales Corners 53130
ST–Glenn M. Seager, MD
1836 South Ave
La Crosse 54601
608-782-7300
D–Glenn M. Seager, MD
AD–Thomas W. Grossman, MD
11945 W Pioneer Rd
Mequon 53092
414-375-1577

Pathology
(November 1991)
P–Richard A. Komorowski, MD
8700 W Wisconsin Ave
Milwaukee 53226
414-257-6201
S–Bradley K. Beggs, MD
1320 S Wisconsin Ave
Racine 53403
414-636-2212

D–Ronald R. Martins, MD
1855 Hollyhock Lane
Elm Grove 53122
414-554-2285
AD–Raymond C. Zastrow, MD
2400 W Villard Ave
Milwaukee 53209
414-527-8404

Pediatrics
(May 1994)
C–Ordean L. Torstenson, MD
1313 Fish Hatchery Rd
Madison 53715
608-252-8181
ST–Karen Wendelberger, MD
Childrens Hospital of Wisconsin
PO Box 1997
Milwaukee 53201
D–Carl S. L. Eisenberg, MD
3003 W Good Hope Rd
PO Box 17300
Milwaukee 53217-0300
414-352-3100

Physical Medicine and Rehabilitation
(November 1991)
C–Sridhar V. Vasudevan, MD
5000 W Chambers St
Milwaukee 53210
414-447-2089
ST–Keith B. Sperlins, MD
505 Isle Royal
Madison 53705
608-263-8635
D–Ram Parvesh Bhala, MD
3033 S 27th St
Milwaukee 53215
414-649-9998

Plastic Surgery
(April 1993)
C–Ruedi P. Gingrass, MD
9800 W Bluemound Rd
Milwaukee 53226
414-476-7240
S–Paul W. Loewenstein, MD
2300 N Mayfair Rd, Suite 950
Wauwatosa 53226
414-259-9000
D–Harvey M. Bock, MD
2315 N Lake Dr
Milwaukee 53211
414-271-8283
AD–Terrence J. Wilkins, MD
2015 E Newport Ave
Milwaukee 53211
414-963-1700

Preventive Medicine
(March 1992)
C–Peter J. Parthum MPH, MD
S63 W14899 Garden Terr
Muskego 53150
414-422-0553
ST–Jane K. Sliwinski, MD
PO Box 19070
Green Bay 54307
414-496-4744
AD–Jane K. Sliwinski, MD

Continued on next page

$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

If you are a board-certified physician or a candidate for board certification in one of the following specialties, you may qualify for a bonus of up to $30,000 in the Army Reserve.

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A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan, Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a $10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

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MAJOR PAUL A. DENESON, JR.
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Continued from preceding page

Psychiatry
(March 1993)
C–Donald P. Hay, MD
2350 N Lake Dr
Milwaukee 53211
S–Laurens Young, MD
8700 W Wisconsin
Milwaukee 53226
T–Kenneth I. Robbins, MD
617 N Segoe Rd
Madison 53705
D–Rudolf W. Link, MD
8045 Crystal Lake Rd
Lodi 53555
608-592-5608
AD–Pauline M. Jackson, MD
1836 South Ave
La Crosse 54601
608-782-7300

Radiation Oncology
(July 1992)
C–Sally M. Schlise, MD
916 S Monroe
Green Bay 54301
414-433-8184
ST–I. Frank Wilson, MD
8700 W Wisconsin Ave
Milwaukee 53226
D–Sally M. Schlise, MD
916 S Monroe
Green Bay 54301
414-433-8184
AD–Robert H. Greenlaw, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-7637

Radiology
(October 1991)
C—Thomas Hinke, MD
Marshfield Clinic
Dept. of Radiology
1000 N Oak St
Marshfield 54449
715-387-5261

ST—Marcia J.S. Richards, MD
St. Lukes Medical Center
Dept. of Radiology
2900 W Oklahoma Ave
Milwaukee 53215
414-649-6420
D–Timothy T. Flaherty, MD
547 E Wisconsin Ave
Neenah 54956
414-722-8600

Residents
C–Elisa G. Triffleman, MD
B6/210 UW CSC
600 Highland Ave
Madison 53792
608-263-6114
D –Jean M. Loftus, MD
F4/214 UW CSC
600 Highland Ave
Madison 53792
608-263-7064
AMA D–Jean M. Loftus, MD

Surgery
(April 1992)
C–Jonathan B. Towne, MD
8700 W Wisconsin Ave
Milwaukee 53226
414-257-5516
ST–Barry J. Seidel, MD
PO Box 549
Woodruff 54568
715-356-3292
D–James P. Quenan, MD
209 - 4th Ave West
Shell Lake 54871
715-468-2711
AD–Louis C. Bernhardt, MD
1313 Fish Hatchery Rd
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608-252-8000

Urology
(April 1992)
D–Stuart W. Fine, MD
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AD–Charles W. Troup, MD
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414-433-6054

Young Physicians
(April 1992 and 1993)
C–Mark H. Andrew, MD
PO Box 72
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608-637-3195
CE–Benjamin C. Wedro, MD
PO Box 1025
La Crosse 54602
608-782-7300
PC–Daniel M. Stormont, MD
1905 Fifth St
Monroe 53566
608-325-1900
D–Gary L. Bryant, MD
1836 South Ave
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608-782-7300
AD–Peter S. Foote, MD
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AMA D–Kevin T. Flaherty, MD
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Wausau 54401-0589
715-845-8201
AMA D–Kevin A. Jessen, MD
1112 Charles Dr
Tomah 54660
608-372-4111
AMA AD–Susan L. Turney, MD
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Marshfield 54449-5777
715-389-4255
MBR-LG–Kathleen M. Wick, MD
1904 Huebbe Parkway
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608-362-5670 ❑

Presidents and secretaries, Wisconsin specialty societies

As of June 1, 1991

Key: president (P), president elect (PE), vice president (VP), chair (C), vice chair (VC), secretary-treasurer (ST), secretary (S), treasurer (T), executive director (ED), executive secretary (ES), chapter administrator (CA)

Wisconsin Allergy Society
P–Martin J. Voss, MD
733 W Clairemont Ave
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Eau Claire 54702-1510
715-839-5286
ST–Marcus Cohen, MD
1 S Park St, Suite 440
Madison 53715
608-282-8435
PE–Martin L. Lobel, MD
324 E Wisconsin Ave, #900
Milwaukee 53202
414-271-4204

Wisconsin Society of Anesthesiologists
P–Anne M. Fagan, MD
1300 Lake Dr
South Milwaukee 53172
ST–W. Stuart Sykes, MD
1005 Columbia Ave
Madison 53705
608-233-4486

Wisconsin Chapter: American College of Cardiology
P–A. James Liedtke, MD
University Hospital & Clinics
600 Highland Ave
Madison 53792
ST–Tamara S. Bergen, MD
Beloit Clinic
1905 Huebbe Parkway
Beloit 53511
608-364-2255

Wisconsin Dermatology Society
P–Michael J. Smullen, MD
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414-499-0696
PE–David K. Falk, MD
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608-252-8000
ST—William LeFeber, MD
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Milwaukee 53202
414-271-2721

Wisconsin Chapter: American College of Emergency Physicians
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PO Box 2901
Milwaukee 53201-2901
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VP–Thomas J. Luetzow, MD
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Larsen 54947
414-836-2761
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PO Box 1458
Fond du Lac 54935
414-921-5330
T–C. Peter Erskine, MD
718 Oneida Place
Madison 53711
ED–Karen Teske-Osborne
999 S Park St
Madison 53715
608-255-2122

Wisconsin Academy of Family Physicians
P–Terry L. Hankey, MD
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Waupaca 54981
715-258-0200
PE– John W. Beasley, MD
777 S Mills St
Madison 53715
608-263-7373
ST–Lowell H. Keppel, MD
180 W Grange Rd
Milwaukee 53207
414-744-4304
ES–Robert H. Herzog
850 Elm Grove Rd
Elm Grove 53122
414-784-3656

Wisconsin Society of Internal Medicine
P–Robert E. Phillips, MD
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Marshfield 54449-5777
715-387-5852
PE– Richard A. Dart, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5345
ST–Bruce A. Polender, MD
1836 South Ave
La Crosse 54601
608-782-7300
ED–Sandy Koehler
611 E Wells St
Milwaukee 53202
414-276-6445

Wisconsin Neurological Society
P–Robert T. Schmidt, Jr, MD
720 S Van Buren
Green Bay 54301
414-436-7100
PE–Thomas J. Zweifel, DO
1440 N 25th St
Sheboygan 53081
414-457-3737
VP–Gary Leo, MD
2320 N Lake Dr
Milwaukee 53211-4665
414-225-8032
ST–Stephen V. Somerville, MD
720 S Van Buren
Green Bay 54301-3525

Continued on next page

Continued from preceding page

Wisconsin Neurosurgical Society
P–Lincoln F. Ramirez, MD
H4/334 CSC
600 Highland Ave
Madison 53792
608-256-1901
PE–Robert A. Narotzky, MD
733 W Clairemont Ave
PO Box 1510
Eau Claire 54702-1510
715-839-5270
ST–Mohammed Rafiullah, MD
3001 Michigan Blvd
Racine 53402
414-637-6106

Wisconsin Section: American College of Obstetrics and Gynecology
C–Charles Hammond, MD
411 Lincoln St
Neenah 54956
414-727-4304

Wisconsin Society of Obstetrics and Gynecology
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Marshfield 54449-5777
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PE–Robert J. Jaeger, MD
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Stevens Point 54481
715-341-0590
ST–Everett A. Beguin, MD
1836 South Ave
La Crosse 54601
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Wisconsin Academy of Ophthalmology
P–Peter J. Mc Canna, MD
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Madison 53715
608-258-4520
ST–Jack L. Hughes, MD
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414-259-1930
ES–Robert H. Herzog
850 Elm Grove Rd, #11
Elm Grove 53122
414-784-3747

Wisconsin Orthopaedic Society
P–Joseph C. DiRaimondo, MD
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Manitowoc 54220
414-682-6376
ST–William R. Niedermeier, MD
2 W Gorham St
Madison 53703
608-255-9414

Wisconsin Society of Otolaryngology-Head and Neck Surgery
P–Steven L. Overholt, MD
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La Crosse 54601
608-782-7300
PE–Steven Millen, MD
11035 W Forest Home Ave
Hales Corners 53130
ST–Glenn M. Seager, MD
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608-782-7300

Wisconsin Society of Pathologists
P–Richard A. Komorowski, MD
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PE–Jay F. Schamberg, MD
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West Allis 53227
414-546-6350
VP–Gerald A. Hanson, MD
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S–Bradley K. Beggs, MD
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T–Ronald R. Martins, MD
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Elm Grove 53122
414-554-2285
ES–Robert H. Herzog
850 Elm Grove Rd
Elm Grove 53122
414-784-3646

Pakistani Physicians Society of Wisconsin
P–Ayaz M. Samadani, MD
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PO Box 678
Beaver Dam 53916
414-887-7731
VP–Mohammad Shafi, MD
2000 W Kilbourn Ave, #C312
Milwaukee 53233
414-342-3000
S–Magbool Arshad, MD
2040 W Wisconsin Ave
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414-342-7300
T–Saleem Bakhtiar, MD
1004 E Sumner St
Hartford 53027
414-673-5050

Wisconsin Chapter: American Academy of Pediatrics
P–Ordean L. Torstenson, MD
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608-252-8181
PE–Kathryn P. Nichol, MD
2753 Marshall Parkway
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ST–Joanne A. Selkurt, MD
1933 Park St
Whitehall 54773
CA–Beth A. Johnson
7500 N Range Line Rd
Milwaukee 53209

Philippine Medical Association-Wisconsin
P–Jeremis B. Vinluan, MD
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Milwaukee 53208
414-342-2606
PE–Miguel T. Galang, MD
9008 W Burleigh St
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414-258-4378
S–Nina Vicente, MD
2040 W Wisconsin Ave, #419
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414-342-9800
S–Violeta A. Singson, MD
2040 W Wisconsin Ave, #754
Milwaukee 53233
414-344-3080

T–Romeo C. Lo, MD
6815 W Capitol Dr
Milwaukee 53216

Wisconsin Society of Physical Medicine and Rehabilitation
P–Donna D. Davidoff, MD
N10132 W23 Gettysburg
Mequon 53092-5456
414-225-8133
PE–Sridhar V. Vasudevan, MD
5000 W Chambers St
Milwaukee 53210
414-447-2089
ST–Keith B. Sperling, MD
505 Isle Royal
Madison 53705
608-263-8635

Wisconsin Chapter: American College of Physicians
P–Joseph J. Mazza, MD
1000 N Oak Ave
Marshfield 54449-5777
S–Kenneth I. Gold, MD
1905 Huebbe Parkway
Beloit 53511
608-364-2240
T–Susan L. Turney, MD
1000 N Oak Ave
Marshfield 54449-5777
715-387-5435

Wisconsin Society of Plastic Surgeons
P–Harvey M. Bock, MD
2315 N Lake Dr, Suite 807
Milwaukee 53211
414-271-8283
VP–Venkat Rao, MD
600 Highland Ave
Madison 53792
ST–Andreas Doermahn, MD
2015 E Newport, #401
Milwaukee 53211
414-963-1700

Wisconsin Society for Preventive Medicine
P–Henry A. Anderson III, MD
1 W Wilson St
PO Box 309
Madison 53701-0309
608-266-1253

ST–Constantine Panagis, MD
9609 W Hadley St
Milwaukee 53222
414-453-9067

Wisconsin Psychiatric Association
P–William T. McKinney, MD
CSC, Psychiatry Department
600 Highland Ave
Madison 53792
608-263-6127
PE—Joseph Tobin, MD
Northwest Psychiatric Clinic
2125 Heights Dr, Suite 3H
Eau Claire 54704
715-834-2751
S–June Patrick, DO
1220 Dewey Ave
Wauwatosa 53213
414-258-2600
T–Kenneth I. Robbins, MD
617 N Segoe Rd
Madison 53705
608-238-5151
ES–Edward S. Levin, JD
1121 N Waverly Place
Suite 1302
Milwaukee 53202
414-223-4455

Wisconsin Council of Child and Adolescent Psychiatry
P–Guy R. Lord, MD
409 E Silver Spring Dr
Milwaukee 53217
414-258-0741
PE–William J. Swift, J, MD
B6/262 UW CSC
600 Highland Ave
Madison 53792
608-263-6099
T–Mary Pearlman, MD
236 Lakewood Blvd
Madison 53704
S–Edward S. Orman, MD
2131 S Webster Ave
Green Bay 54301
414-435-8816

Wisconsin Society of Radiation Oncologists
P–Sally M. Schlise, MD
916 S Monroe St
Green Bay 54301
414-433-8184
VP–Richard A. Steeves, PhD, MD
K4/B100 UW CSC
600 Highland Ave
Madison 53792
608-263-8500
S–J. Frank Wilson, MD
Dept of Radiation Therapy
8700 W Wisconsin Ave
Milwaukee 53226

Wisconsin Radiological Society
P–Thomas E. Hinck, MD
Marshfield Clinic
Dept. of Radiology
1000 N Oak Ave
Marshfield 54449
715-387-5261
PE–Paul R. Bolich, MD
1586 Arapahoe Ct
Green Bay 54303
414-494-1600
VP–Joseph F. Sackett, MD
University Hospital
Dept. of Radiology
600 Highland Ave
Madison 53792
608-263-9180
ST–Marcia J.S. Richards, MD
St. Lukes Medical Center
2900 W Oklahoma Ave
Milwaukee 53215
414-649-6420

Wisconsin Surgical Society
P–Jonathan B. Towne, MD
8700 W Wisconsin Ave
Milwaukee 53226
414-257-5516
PE–J. David Lewis, MD
635 W Hickory St
West Bend 53095
414-338-1123
ST–Barry J. Seidel, MD
9601 Townline Rd
Minocqua 54548
715-358-1000

Wisconsin Chapter: American College of Surgeons
P–Paul S. Fox, MD
1111 Delafield St
Waukesha 53188
414-542-0444
PE–James H. Woods, MD
2300 N Mayfair Rd, Suite 845
Wauwatosa 53226
414-453-2121

VP–Ronald D. Wenger, MD
1912 Atwood Ave
Madison 53704
608-241-4611
ST–John S. Blackwood, MD
17050 W North Ave
Brookfield 53005
414-786-3722

Wisconsin Urological Society
P–Edward M. Messing, MD
600 Highland Ave
Madison 53792
608-263-9534
ST-Frank P. Begun, MD
9200 W Wisconsin Ave
Milwaukee 53226
414-259-2795

Impaired Physician Program

The Statewide Impaired Physician Program functions under the purview of the Commission on Mediation and Peer Review, although its activities are managed by a seven-member managing committee. The program protocol guides the general handling of inquiries or concerns regarding identified impaired physicians. Available to Wisconsin licensed physicians, the program offers education, identification, assessment, and compassionate intervention. The program refers patients to acceptable facilities for evaluation or treatment, and monitors a 2-year follow-up after completion of initial therapy. Through its efforts, a number of physicians have been encouraged by compassionate colleagues to enter structured rehabilitation.

Literature on the subject contends that from 10% to 14% of practicing physicians have difficulty with alcohol and drugs. Some research suggests that, during a lifetime, one in ten physicians will abuse alcohol in professional circumstances, so as to be identified as impaired.

Unfortunately, many people in a position to observe and identify impaired physicians do not know what to do when they perceive a problem, nor do they realize that help is available from organized programs. Furthermore, individuals such as medical staff members, hospital administrators, and others are reluctant to report a physician to an organized program. Their initial reaction is to not get involved, or to conclude that the problem can be handled by someone else in some other manner. This attitude often results in delayed intervention and treatment, or in passive action which ultimately fails. Others, who might otherwise report an impaired physician may seek legal advice, only to be told by lawyers to be noncommittal and to respond only to a subpoena. Such advice could be a deterrent to early intervention.

Current techniques of identification, intervention, assessment, treatment, and follow-up of impaired physicians are not well known in the medical community. Physicians are not generally adequately trained or skilled in identification, diagnosis, and treatment of patients with chemical dependency. As a result, few are able to respond adequately when they accept an impaired physician as a patient.

Through efforts of the Managing Committee, the SMS Board of Directors approved the concept of contracting with a part-time medical director to provide continuous program leadership and activity. The SMS House of Delegates adopted the Board's recommendation and approved a $15 dues increase to fund the position.

Phase I

Education and prevention

Target individuals and groups are educated to understand physician chemical dependency. They learn symptoms of impairment; techniques of early identification and prevention; resources available for identification, assessment, intervention, and treatment; and social, financial, legal and other problems associated with impairment.

Primary target groups

- Physicians: Meetings of hospital medical staffs, county medical societies, regional or statewide continuing medical education, and accredited seminars, (eg at the SMS annual meeting).
- Hospital personnel: Hospital administrators and medical directors, chiefs of medical staffs, hospital boards of trustees, directors of nursing and pharmacy, and others (eg anesthetists and technicians). Consultation for medical staff officers on establishing effective impaired

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physician committees or programs in hospitals. "Guidelines for Physician Aid Committees of Hospital Medical Staffs" have been distributed to all Wisconsin general hospitals with encouragement to implement them in cooperation with medical staffs. Copies of guidelines are available upon request.

- Pharmacists, nurses, and nursing home administrators: Lectures at association meetings, or in combination with physician and hospital personnel meetings.
- Spouses and families of physicians: Educational material available at state and county medical society and auxiliary meetings.
- Legal profession: Urge lawyers, whose state association has its own impaired lawyers program, to encourage their physician clients to use organized medicines voluntary impaired physicians programs, when a perceived need arises.
- Teaching staff. The teaching staff presents educational and prevention programs to the various target groups. The physician team approach is employed, with at least one team member being in the process of recovering from alcohol or other chemical dependency.

Literature is available to assist in an understanding of the disease of chemical dependency, and to explain intervention, treatment and follow-up resources.

Phase II
Intervention and treatment

Successful programs include the availability of physician interveners to perform compassionate colleague-to-colleague contact with physicians identified as impaired.

Approximately 35 trained physicians throughout Wisconsin are available to meet with and urge impaired colleagues to leave the medical practice to enter suitable programs for evaluation and treatment. Programs considered suitable are those which comply with Impaired Physician Program requirements.

Interveners act as teams. At least one intervener is either expert in or recovering from the impairment of concern. The initial intervention is always a compassionate encounter. The Wisconsin program has no interest in the punitive or coercive approach until all benevolent measures have been exhausted. An intervener's interests are the personal well-being of a colleague, and the quality of health care for patients.

The Statewide Physician Program has learned that physicians achieve a more satisfactory recovery status when they receive intensive treatment for chemical dependency in facilities which espouse the medical model of therapy, under which the physician is seen by the physician addiction specialist on a frequent, if not daily basis. Within this model, the program has established certain requirements for satisfactory primary treatment of chemical dependency.

Physicians suffering from emotional illness or senility, or from the sequelae of stress when these are uncomplicated by chemical dependency, will be encouraged to seek assessment, treatment, or both, through Statewide Program approved facilities or practitioners.

The program adheres to the policy that satisfactory recovery from chemical dependency can only be realized through a monitored 2-year recovery period. It considers the 2-years after hospitalization to be vital to assuring continued recovery.

Phase III
Benevolent assistance

In addition to the burdens of impairment, some physicians are financially unable to pay the cost of in-patient care. By estimate, at least 10% of Wisconsin impaired physicians have either no or inadequate health insurance. Some have been ill for so long that their financial resources essentially have been depleted. About 10% of the charges for rehabilitation of such physicians go unpaid. For 20% of impaired physicians, residence and treatment in recovery homes (average of three months stay, at a cost of $1,900 per month) is essential for completion of the 2-year recovery program.

With approval of the SMS and CES Foundation Board of Directors, the Impaired Physician Program established a Physicians Benevolent Assistance Fund with pledges to the CES Foundation. The fund appeal among SMS members and Wisconsin hospitals was designed to develop a fund of $150,000 for low-interest loans to impaired physicians who can potentially repay the loan(s) after returning to medical practice. ❑

A call for photographs

The *Wisconsin Medical Journal* and the SMS Charitable, Educational, and Scientific Foundation are joining forces in an effort to build a photographic library of medicine in Wisconsin. Donations of current or historical photos relating to medicine–persons or places, equipment or events–are welcome and tax deductible. All donated photos will become the property of the Fort Crawford Medical Museum, which is owned and operated by the foundation, and may be used to illustrate future issues of the *Wisconsin Medical Journal*. Send your photos to: Thomas L. Adams, CAE, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701-1109.❑

SMS physicians' support group

The SMS Medical Liability Committee in 1987 created the Physicians' Support Program to help physicians and their families cope with the stress of being sued for malpractice. The program provides emotional support, practical information, and an opportunity for the physician and spouse to share their feelings with sympathetic listeners.

How the program works

When a physician is sued for medical malpractice, the SMS sends him or her a packet of materials that includes a letter explaining the Physicians' Support Program, practical advice on coping with the experience, and a list of physicians and spouses who have volunteered to serve as members of a special support group. A similar packet is sent to the physician's spouse about a week later. The program was recently expanded, and this year a second packet that contains material offering practical tips on preparing for litigation and a description of the workings of the Medical Mediation Panels and a resource bibliography is also mailed to these physicians.

The Physician's support group

The purpose of the support group is to offer emotional support and practical advice for dealing with a medical malpractice suit. The emphasis is on personal contact and communication between the physician or spouse requesting help and the panel member. The setting of meetings is left entirely to the parties involved, and may be limited to telephone calls, if so desired. Topics covered during meetings are expected to be wide ranging, (eg feelings of hostility, fear, loss of confidence, difficulty in making decisions, and withdrawal from the family) but discussions of the specific merits of the case are avoided. The emphasis is on individual interaction and open and frank discussions. There are no group sessions. Confidentiality is assured in all cases.

Any practicing physician who has been a respondent in a malpractice action and feels he or she can offer emotional support to a colleague in a similar situation is encouraged to volunteer as a support group member. Spouses who can provide support for their counterparts are also invited to participate. Each panelist receives basic information about the program and advice on how to be an effective participant.

Physicians interested in participating in the Physicians' Support Group should contact Kay Hutchison in the Division of Medical Policy and Practice at the SMS. ▫

Letter to physician named in a medical mediation case

Items mentioned in this letter as "enclosed" are available from the Division of Medical Policy and Practice at SMS.

Dear Doctor:

According to our records, you have been named in a medical mediation case. Feelings such as anger, frustration and depression are common for physicians involved in a malpractice action. I am writing this letter to inform you that there are other physicians and spouses who have been through similar experiences and are willing to discuss those feelings.

As part of the work of the Medical Liability Committee, we have looked at the effect of the medical malpractice action on the physician and his/her family. It was the recommendation of the Medical Liability Committee to the Board of Directors that the State Medical Society establish a support structure for physicians and their families involved in medical malpractice actions. Part of our proposal recommended the establishment of a group of physicians and spouses who could serve as "sympathetic listeners" for the physicians and their families involved in a liability action.

I invite you and your spouse or significant other to use the program. The SMS Auxiliary strongly supported the creation of the support group, because it would be very beneficial to family members. We will be sending a letter to your spouse describing the program in approximately one week. Enclosed is a list of physicians and spouses who have volunteered to serve. Please feel free to contact any physician or spouse on the list. He or she will assure you of maintaining confidentiality.

Also, enclosed is a brief description of the program and helpful materials to cope with the stress associated with medical litigation. Specific information concerning the Wisconsin Medical Mediation Panels and the litigation process will be sent to you within the next two weeks. Remember, talking to an experienced, knowledgeable peer about your frustrations is important. If you have further questions about the program or would like additional information, please feel free to contact Kay Hutchison at SMS, 1-800-362-9080.

Sincerely,

Thomas M. Kidder, MD
Chair, Medical Liability Committee

Mediation and peer review services

When misunderstandings arise about what the physician hopes to accomplish and what the patient expects it is important that the patient discuss with the physician any questions about the medical care received. If they are not resolved, however, the SMS provides a means for resolving these differences.

The SMS Commission on Mediation and Peer Review receives, investigates, and resolves complaints and inquiries from patients and others, concerning Wisconsin physicians. The commission's standard of judgment is what constitutes good medical care. Physicians, too, may benefit from commission efforts to mediate differences between themselves.

Many complaints and questions received by SMS staff are resolved by telephone. By protocol, however, only written complaints will be considered by the commission. If all affected parties reside within the boundaries of a single county medical society, that society may assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

A protocol manual was developed by the Commission on Mediation and Peer Review and approved by the Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test physician practice patterns, and responding to inquiries or requests for action regarding impaired physicians. The manual was designed to accommodate informal disposition of minor and uncomplicated complaints, as well as complex and serious matters which may involve due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of a physician's SMS membership. The manual is available upon request.

Certain complaints received by the commission are evaluated by subcommittees, members of which submit reports and recommended resolutions to the commission chair. Frequently, these subcommittee conclusions are transmitted to the subject physicians, and as appropriate, to complainants. All subcommittee activities are reported to the commission. Matters of a more serious nature require additional use of the manual, as necessary.

The Commission on Mediation and Peer Review offers peer review services to private and governmental organizations and to physicians, including utilization review, appropriateness of patient care, and quality assurance. Although it is empowered to initiate disciplinary action, the commission's most valuable peer review benefits have been educational, judging from physician's expressed appreciation for the commission's consultation in matters of proper patient care.

The commission maintains purview over the Statewide Impaired Physician Program and continues its interest in the Coordinating Council on Physician Impairment of the SMS and the Medical Examining Board. The commission participates in the Medicaid Medical Audit Committee, under contract between the SMS and the Wisconsin Department of Health and Social Services.

Commission members will also review cases submitted by physicians who are the subject of Medicare or Medicaid reviews, to provide an independent assessment of the appropriateness of care provided. In those instances where the commission disagrees with a WIPRO or other review organization finding, the commission will provide the physician with independent medical opinion in any further action taken by the review agencies. ▫

Accreditation program for continuing medical education

THE SMS'S ACCREDITATION program functions under the authority of the AMA's Accreditation Council for Continuing Medical Education (ACCME). Representatives from state medical societies, national medical specialty societies, the AMA Section on Medical Schools and Resident Physician's Section, the National Medical Association, the American Hospital Association, the Association for Hospital Medical Education, the Federation of State Medical Boards, and medical specialty boards comprise the ACCME.

The SMS Commission on Continuing Medical Education currently reviews and accredits 56 hospitals, 24 specialty societies, two professional organizations, and one county medical society in Wisconsin. Information is available from Kristin Bjurstrom Krueger or Lisa Lawry at the SMS.

Category 1
CME activities with accredited sponsorship. Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization.

Category 2
CME activities with an accredited or non-accredited organization.

- CME lectures and seminars not designated as Category I by an accredited sponsor;
- medical teaching;
- articles, publications, books, and exhibits;
- non-supervised individual CME, including self-instruction, consultation, patient care review, and self assessment; and
- other meritorious learning experiences.

The following Wisconsin organizations were accredited by SMSW and ACCME for continuing medical education programming as of Jan 1, 1990:

Accredited hospitals
Appleton Memorial and St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Fort Atkinson Memorial Hospital, Fort Atkinson
Gundersen Medical Foundation, Ltd and La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital at Oconomowoc, Oconomowoc
Mendota Mental Health Institution, Madison
Mercy Hospital, Janesville
Mercy Medical Center, Oshkosh
Meriter Hospital, Madison
Reedsburg Memorial Hospital, Reedsburg
Riverside Community Hospital, Waupaca
Sacred Heart Hospital, Eau Claire
Sacred Heart-St Mary's Hospital, Inc, Rhinelander
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial-St Nicholas Hospitals, Sheboygan
Sinai Samaritan Medical Center, Milwaukee
St Agnes Hospital, Fond du Lac
St Anthony's Family Medical Center, Milwaukee
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Medical Center, La Crosse
St Francis Hospital, Milwaukee
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital-Ozaukee, Port Washington
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay
Stoughton Hospital Association, Stoughton
Theda Clark Regional Medical Center, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospital Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

Accredited specialties
American Cancer Society, Wisconsin Affiliate, Madison
American Heart Association of Wisconsin, Milwaukee
Arthritis Foundation, Wisconsin Chapter
Blount and Schmidt Spinal Study Group
Fox Valley Academy of Medicine
Milwaukee Academy of Medicine
Milwaukee Gynecological Society

Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
Racine Academy of Medicine
Wisconsin Academy of Family Physicians
Wisconsin Academy of Ophthalmology
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Neurological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Otolaryngology–Head and Neck Surgery
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
Wisconsin Society of Radiation Oncologists
Wisconsin Urological Society

Accredited county medical societies
Marinette-Florence County Medical Society

Other accredited organizations
Physicians Insurance Company of Wisconsin
Wisconsin Association of Medical Directors

ACCME accredited
Medical College of Wisconsin
UW Center for Health Sciences
Interstate Postgraduate Medical Association
State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists ▫

Membership facts

Whether you are just starting medical school, engaged in postgraduate training, maintaining a full-time practice, or retired, the SMS has a membership classification to fit your needs. Election to membership by the county medical society in which your principal place of practice is located carries with it membership in the SMS and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. You may also qualify for reduced dues during the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Regular membership dues in 1992 are $595 for the SMS and $400 for the AMA; county society dues vary.

Dues for regular, part-time practice, or over-age-70 membership classifications may be paid in one lump sum or in two equal installments, with the first half due by Oct 1, 1991, and the second half by Jan 1, 1992.

An incentive plan is available for early payment of county and state dues: 5% off state dues for those who pay state and county dues in full by Oct 1, 1991.
A more detailed list of SMS membership classifications and their corresponding dues follow.

SMS Membership classifications

Regular: Member in active practice. Regular members who are in their first or second year out of residency, fellowship, or military obligation may qualify for reduced dues for the SMS, the AMA, or both.

Part-time practice: Physician regardless of age who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Resident: Member who as of Jan 1 of the dues year is in an approved training program as a hospital resident or research fellow and is licensed to practice medicine and surgery in Wisconsin.

Military service: Member who is serving in the US armed forces or US Public Health Service (generally not to exceed 5 years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Retired: Member who has completely retired from practice (works less than 240 hours each year). All dues are waived unless county society indicates it wishes to charge county dues. (Retired and life members who wish to receive *Medigram* and the *Wisconsin Medical Journal* must pay a $45 publications fee.)

Life: Member who has held membership in a state medical society for 50 years. Past presidents of the SMS are also included in this category.

Honorary: Physician named an honorary member by the Board of Directors for outstanding contributions to the medical profession.

Over age 70: Member in active practice who is over 70 years of age.

Scientific fellow: Person engaged in teaching or research

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in the basic sciences at an accredited college or university–but not holding a degree in medicine or osteopathy–by invitation and consent of the Board of Directors.

Emeritus: Retired member who has chosen not to renew his or her license.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

1992 Dues

	SMS	*AMA*	*County*
Regular	$595	$400	Normal county dues
First year in practice	$297	$200	Normal county dues
Second year in practice	$446	$300	Normal county dues
Two physician family	$545	$400	Normal county dues
Part-time practice	$297	$400	Normal county dues
Part-time over age 70	$297	$200*	Normal county dues
Resident	$ 70	$ 45	Varies
Military service	-0-	$264/$45	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$400/$80/-0-*	-0-
Retired, over age 70	-0-	-0-	-0-
Life	-0-	$400/-0-*	-0-
Honorary	-0-	$400/-0-*	-0-
Over age 70	$297	$400/-0-*	Normal county dues
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-
Candidate:			
Student	$ 20[1]	$ 20[2]	-0-
Postgraduate-one	$ 10	$ 45	Varies

[1]students' SMS and county dues for four academic years
[2]students' AMA dues for the calendar year 1992

*Physicians in these categories may be eligible for exemption from AMA dues under the grandfather clause. (AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria, with the exception of financial hardship or disability, will automatically be exempt from dues in 1986 and the years following.)

Current AMA policy provides for only two categories of exemptions: financial hardship or disability and 70 years of age or older and fully retired. AMA dues for under-age-70 and fully retired members may be reduced to $80.

State society dues are prorated on a monthly basis for those elected to membership July 1 through Aug 31. Those elected after Aug 31 are exempt from dues for the balance of the year in which they are elected. AMA dues are prorated on a semiannual basis.

To begin the membership process, contact your county medical society or call the Communications Division of the SMS at 1-800-362-9080 or 608-257-6781.❑

SMS officers and directors by district

Officers of the Society
President (1991-1992)
Cyril M. Hetsko, MD, 1313 Fish Hatchery Rd
Madison 53715

President elect (1991-1992)
William J. Listwan, MD, 205 Valley Avenue
West Bend 53095

Secretary-General Manager (1991-1992)
Thomas L. Adams, CAE, 330 E Lakeside St
PO Box 1109, Madison 53701

Treasurer (1991-1992)
Pauline M. Jackson, MD, 1836 South Ave
La Crosse 54601

Board of Directors
Chair: Richard H. Ulmer, MD
Vice chair: Raymond C. Zastrow, MD

District 1
Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha counties

Robert F. Purtell, Jr, MD (1989/1989-1992)
3316 W Wisconsin Ave, Milwaukee 53208

Thomas A. Reminga, MD (1986/1989-1992)
2025 E Newport Ave, Milwaukee 53211

Raymond C. Zastrow, MD (1987/1989-1992)
2400 W Villard Ave, Milwaukee 53209

Timothy G. McAvoy, MD (1990/1990-1993)
1751 E Main, Waukesha 53186

Marvin G. Parker, MD (1990/1990-1993)
1525 Howe St, Racine 53403

Charles E. Pechous, Jr, MD (1990/1990-1993)
6530 Sheridan Rd, Kenosha 53140

Marcia J. S. Richards, MD (1988/1990-1993)
2900 W Oklahoma Ave, PO Box 2901, Milwaukee 53201-2901

John E. Ridley, III, MD (1990/1990-1993)
2315 N Lake Dr, Ste 1001, Milwaukee 53211

Jay F. Schamberg, MD (1991/1991-1993)
8901 W Lincoln St, West Allis 53227

Frank H. Urban, MD (1987/1990-1993)
10425 W North Ave, Wauwatosa 53226

George R. Schneider, MD (1989/1991-1994)
9330 W Lincoln Ave, West Allis 53227

Richard H. Strassburger, MD (1988/1991-1994)
161 W Wisconsin Ave, Ste 4016, Milwaukee 53203

District 2
Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, and Sauk counties

John D. Wegenke, MD (1986/1989-1992)
345 W Washington Ave, Madison 53703

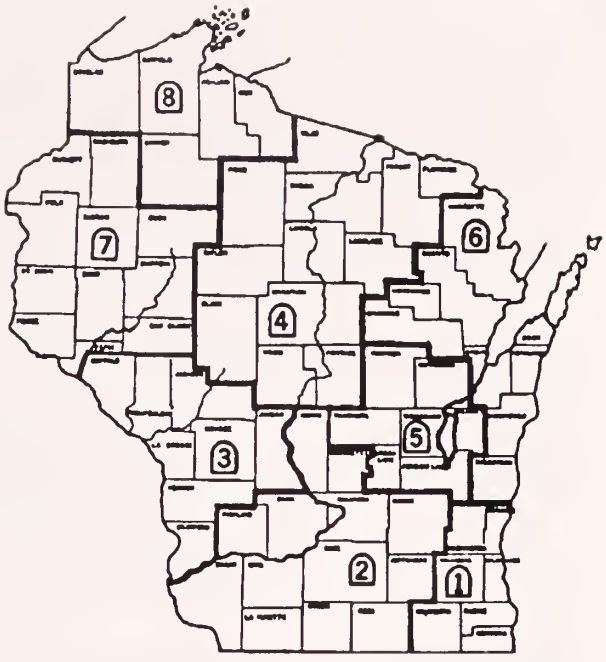
Peter L. Eichman, MD (1987/1990-1993)
H4/622 UW CSC, 600 Highland Ave, Madison 53792

Jan E. Erlandson, MD (1990/1991-1994)
2630 20th Ave, Monroe 53566

William L. Kopp, MD (1989/1991-1994)
1313 Fish Hatchery Rd, Madison 53715

Sandra L. Osborn, MD (1987/1991-1994)
1912 Atwood Ave, Madison 53704

Ayaz M. Samadani, MD (1991/1991-1994)
P.O. Box 678, 148 Warren St, Beaver Dam 53916



District 3
Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Trempealeau, and Vernon counties

Jack M. Lockhart, MD, (1989/1989-1992)
1836 South Ave, La Crosse 54601

District 4
Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, and Wood counties

William E. Raduege, MD (1986/1989-1992)
PO Box 1387, 1112 E 3rd St, Woodruff 54568

Richard H. Ulmer, MD (1986/1989-1992)
1000 N Oak Ave, Marshfield 54449

Robert J. Jaeger, MD (1988/1991-1994):
3291 Thompson Court, Stevens Point 54481

District 5
Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago and counties

James L. Basiliere, MD (1986/1989-1992)
414 Doctors Court, Oshkosh 54901

Donn D. Fuhrmann, MD (1988/1990-1993)
1420 Algoma St, New London 54961

Harry J. Zemel, MD (1987/1991-1994)
430 E Division St, Fond du Lac 54935

Continued on next page

District 6
Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, and Sheboygan counties

Stephen D. Hathway, MD (1989/1989-1992)
PO Box 1700, Green Bay 54305-5000

John E. Kraus, MD (1986/1989-1992)
1510 Main St, Marinette 54143

Joseph C. DiRaimondo, MD (1985/1991-1994)
1636 Miriam Rd, Manitowoc 54220

District 7
Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, and Washburn counties

Marwood E. Wegner, MD (1983/1989-1992)
208 Adams St S, St Croix Falls 54024

Philip J. Happe, MD (1985/1991-1994)
733 E Clairemont Ave, Eau Claire 54701

District 8
Ashland, Bayfield, Douglas, Iron, and Sawyer counties

Robert L. Sellers, MD (1987/1990-1993)
69 N 28th St, Superior 54880

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205 Valley Ave, West Bend 53095
Immediate past president:
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900 S Webster Ave, Green Bay 54301

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777 S Mills St, Madison 53715
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1905 Huebbe Parkway, Beloit 53511

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M. Zuhdi Jasser, medical student, Medical College of Wisconsin

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8430 W Capitol Dr, Milwaukee 53222
John K. Scott, MD (1990/1991 & 1992)
20 S Park St, #350, Madison 53715
Patricia J. Stuff, MD (1990/1991 & 1992)
PO Box 366, Bonduel 54107
Richard W. Edwards, MD (1991/1992 & 1993)
1313 W Seminary St, Richland Center 53581
Timothy T. Flaherty, MD (1991/1992 & 1993)
547 E Wisconsin Ave, Neenah 54956
John D. Riesch, MD (1991/1992 & 1993)
PO Box 427, Menomonee Falls 53051

Alternate Delegates to the AMA
Jerome W. Fons, Jr, MD (1990/1991 & 1992)
3734 W Coldspring Rd, Greenfield 53221
Cyril M. Hetsko, MD (1990/1991 & 1992)
1313 Fish Hatchery Rd, Madison 53715
Robert F. Purtell, Jr, MD (1990/1991 & 1992)
3316 W Wisconsin Ave, Milwaukee 53208
J D Kabler, MD (1991/1992 & 1993)
1552 University Ave, Madison 53705
Richard H. Ulmer, MD (1991/1992 & 1993)
1000 N Oak Ave, Marshfield 54449
Kenneth M. Viste, Jr, MD (1991/1992 & 1993)
100 Stoney Beach Rd, Oshkosh 54901

Young Physicians Section Delegates to the AMA
Kevin A. Jessen, MD (1991-1992)
1112 Charles Dr, Tomah 54660
Kevin T. Flaherty, MD (1990-1992)
PO Box 689, Wausau 54402

YPS Alternate delegate to the AMA
Susan Turney, MD (1991-1993)
1000 North Oak Avenue, Marshfield, WI 54449-5777

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions and committees are elected at the annual meeting (April 1991). Dates in parentheses indicate year of appointment and beginning and expiration of terms of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the annual meeting.❑

SMS resource directory

TIMELY, ACCURATE INFORMATION is essential in our complex, rapidly changing medical environment. Information—when you need it—on scientific issues, legislative issues, and socioeconomic issues is available from the SMS headquarters in Madison.

This SMS resource directory is provided as a brief reference guide to assist you in locating the resource person on the SMS staff who is best able to answer your questions on a wide variety of topics.

Simply call 1-800-362-9080 for immediate access to this valuable membership resource.

A
Accounting ..... Jim Esselman
Accounts payable
SMS Holdings, Corp ..... Kris Hensen
SMS/WMJ ..... Rick Koffarnus
Accounts receivable
SMS Holdings, Corp ..... Marcella Herfel/Kris Hensen
SMS/WMJ ..... Marcella Herfel/Kris Hensen
Membership dues ..... County societies/Jim Lundberg/Joyce Pease
Insurance premiums ..... Heidi Ness
Accreditation for CME ..... Kristin Krueger
Address changes ..... Joyce Pease
Administrative rules (state) ..... Michael Kirby/Don Lord/Sally Wencel
Advanced medical directives ..... Sally Wencel
Aesculapian Society ..... Julie Hein
Aging and extended care facilities ..... Linda Boyd
AIDS ..... Sara Schwartz
Alcoholism and other drug abuse ..... Cecilia Geis
Allied health personnel ..... Sally Wencel
AMA-delegates, policies and activities ..... Deborah Wilke/Jim Paxton/Tom Adams
Annual meeting ..... Kristin Krueger
Antitrust ..... Mark Adams/Sally Wencel

Continued on next page

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The Air National Guard doesn't take just any physician who wants to be a member. We look for people who have only the highest standards themselves when it comes to their profession. Our medical unit is made of people who are dedicated to their medical professions, and who enjoy dedicating time to serve their country. All it takes is two days a month and fifteen days a year to be a member. You'll be eligible for more tangible benefits including a great retirement plan, low-cost insurance, educational advantages, as well as a monthly paycheck. If you qualify, you can even take to the sky as a Flight Surgeon, through a specialized training program. And, when you join the Air Guard you will automatically be comissioned as an officer. It doesn't matter whether you're on the ground or 30,000 feet in the air, the Air National Guard will put your skills to work for America, part-time.

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Madison, WI 53704-2589
1-800-256-8608 · (608)241-6284

AIR NATIONAL GUARD
Americans At Their Best

Continued from preceding page

Audits (T-18), T-19, WIPRO) ..... Trish Ramsay
Audio-visual services ..... Deborah Wilke
Auxiliary ..... vacant

B

Beaumont 500 ..... Julie Hein
Board of Directors ..... Tom Adams/ Jim Paxton
Bylaws: state and county medical ..... Sally Wencel/ Mark Meyer

C

Capitol Update ..... Terry Hottenroth/ Don Lord
CHAMPUS ..... Trish Ramsay
Charitable, Educational and Scientific Foundation ..... Julie Hein
Claim forms ..... Bill Guerten
Communications ..... Deborah Wilke/ Russell King
Complaints about medical care ..... Sally Wencel
Dane County ..... Lanny Hardy
Computers ..... Doug Turecek
Consent forms ..... Sally Wencel
Consumer relations ..... Deborah Wilke
Continuing medical education ..... Kristin Krueger
Cost containment activities ..... Mary Barham
County medical society affairs including Constitution and Bylaws ..... Sally Wencel/ Mark Meyer

D

Data collection ..... Mary Barham
Data systems ..... Doug Turecek
Discipline of physicians ..... Sally Wencel
Donations (monetary, real property, in-kind ..... Julie Hein
DRGs ..... Trish Ramsay

E

Economic information ..... Mary Barham
Editorial Board ..... Deborah Wilke/ Russell King
Emergency medical services ..... Sally Wencel
Environmental health ..... Cecilia Geis
Ethics ..... Sally Wencel/ Mary Barham

F

Fees for medical care or other physician services ..... Sally Wencel
Field Staff ..... Mark Meyer/Martin Mulcahey/ Cheryl McCollum/Steve Whittow
Fort Crawford Medical Museum ..... Julie Hein
Foundation (CESF) ..... Julie Hein

G

General management of SMS ..... Tom Adams/ Jim Paxton
Governmental affairs ..... Terry Hottenroth/ Michael Kirby/Don Lord
Grants for special projects ..... Julie Hein

H

HSS-124 Hospital Code ..... Sally Wencel
Health care costs ..... Mary Barham
Health care data ..... Mary Barham
Health care for the uninsured ..... Cecilia Geis
Health careers ..... Deborah Wilke
Health education ..... Deborah Wilke
Health insurance
third-party carriers ..... Trish Ramsay
for SMS members ..... Jan McChesney
Health manpower ..... Trish Ramsay
HMOs ..... Mary Barham
Hospital bylaws ..... Sally Wencel
Hospital medical staff section ..... Kay Hutchison
Hospital-physician relations and due process ..... Sally Wencel
Hospitals and health facilities ..... Sally Wencel
House of Delegates ..... Tom Adams/ Jim Paxton

I

Impaired physicians ..... Sally Wencel
Insurance and membership programs
Insurance ..... Jan McChesney/ Barbara Kalupa

*Annuities
*Auto
*Dental Protection Plan
*Overhead expense
*Funding of claims made tail coverage
*Professional liability
*Life
*Office
*Disability
*Personal property
*Personal umbrella
*Health
*Retirement plans

Membership programs ..... Noreen Krueger/ Lee Johnson

*Auto leasing plan
*Avis or Hertz rental plan
*Collection service
*Credit cards
*Medical equipment leasing/discounts
*Worker's compensation

International Medical Graduates ..... Cecilia Geis
Interns and residents ..... Linda Boyd
IPAs ..... Mary Barham

J

(JCAHO) Joint Commission on Accreditation of Health Organizations ..... Sally Wencel

L

Legal information ..... Sally Wencel
Legislation and regulations
state ..... Terry Hottentroth/ Michael Kirby/Don Lord/field representatives
Federal ..... Michael Kirby/ Terry Hottenroth
Liability insurance coverage ..... Barbara Kalupa/ Charlie Sitkiewitz

Liability insurance regulation ..... Mark Adams/ Terry Hottenroth
Library ..... Marjorie Stafford/ Marlene Scott
Licensure of physicians and others ..... Sally Wencel
Living wills ..... Don Lord/ Sally Wencel
Long-term care ..... Linda Boyd
Long-term care insurance ..... Charlie Sitkiewitz/ Lori McDowell

M

Mailing labels ..... Jim Lundberg/ Joyce Pease
Marketing in medical care ..... Deborah Wilke
Managed care ..... Mark Adams/ Sally Wencel
Maternal and child health ..... Linda Boyd
Maternal mortality study ..... Linda Boyd
Media relations ..... Deborah Wilke/ Russell King
Mediation panels ..... Mark Adams
Mediation and peer review ..... Sally Wencel
Medicaid (T-19) ..... Trish Ramsay
Medicaid audits ..... Trish Ramsay
Medical assistants ..... JoAnn Steigerwald
Medical history ..... Julie Hein
Medicolegal issues ..... Mark Adams/ Sally Wencel
Medical liability ..... Mark Adams
Medical liability (legislative information and related matters) ..... Terry Hottenroth/ Mark Adams
Medical museum, Prairie du Chien ..... Julie Hein
Medical Policy and Practice Division ..... Mary Barham
Medical records ..... Sally Wencel
Medical student loans
  Applications ..... Julie Hein
  Repayments ..... Norma Swenson/ Jane Anderson
Medical student section ..... Linda Boyd
Medicare (T-18) ..... Trish Ramsay
Medicare audits ..... Trish Ramsay
Medicine, religion and ethics ..... Mary Barham
Medigram ..... Marlene Scott/ Russell King/Deborah Wilke
Membership
  County societies ..... Jim Lundberg/ Joyce Pease/Mark Meyer
Membership Committee ..... Deborah Wilke
Membership recruitment and retention ..... Jim Lundberg/ Deborah Wilke
Mental health ..... Cecilia Geis
Minority health issues ..... Mary Barham

N

National Practitioner Data Bank ..... Sally Wencel/ Kay Hutchison
Negotiations ..... Tom Adams
Newspapers-news releases ..... Deborah Wilke/ Russell King
Nursing ..... Sally Wencel
Nursing homes ..... Linda Boyd/ Terry Hottenroth

O

Occupational health ..... Cecilia Geis
Occupational Health Guide ..... Julie Hein

P

Pamphlets on health care ..... Deborah Wilke
PartnerCare ..... Trish Ramsay
Patient Compensation Fund ..... Mark Adams/ Kay Hutchison
Peer review ..... Sally Wencel
Personnel ..... Barbara Kopenski
Physicians for Better Government ..... Terry Hottenroth/ field representatives
Physician information biographical ..... Jim Lundberg/ Joyce Pease
Physician placement service ..... Marjorie Stafford
Physician recognition award ..... Kristin Krueger
Physician referrals
  Dane County ..... Chris Long
  Other counties ..... Jim Lundberg/ Joyce Pease
Physician Support Program ..... Kay Hutchison
Political action ..... Terry Hottenroth/ field representatives
Power of attorney for health care ..... Sally Wencel
Practice management seminars ..... Karen Garrett
Practice parameters ..... Kay Hutchison
Printing ..... Dave Conner
Professional liability (legislative information and related matters ..... Terry Hottenroth/ Mark Adams
Professional liability insurance ..... Charlie Sitkiewitz/ Barbara Kalupa
Property management-SMS ..... Don Temby
PRO ..... Trish Ramsay
Public affairs ..... Terry Hottenroth/ Michael Kirby
Public health ..... Terry Hottenroth/ Linda Boyd
Public information ..... Deborah Wilke/ Russell King
Public relations ..... Deborah Wilke/ Russell King

Q

Quality assurance ..... Mary Barham/ Sally Wencel

R

Radio ..... Deborah Wilke/ Russell King
RBRVS ..... Trish Ramsay

Continued on next page

Continued from preceding page

Resident physicians ..... Linda Boyd
Risk management ..... Mark Adams/ Kay Hutchison
Rural health ..... Trish Ramsay

S

Safe Transportation ..... Cecilia Geis
Savant syndrome information ..... Julie Hein
School health ..... Mary Barham
Scientific affairs ..... Kristin Krueger
Second opinions ..... Trish Ramsay
Seminars ..... Karen Garrett
Speakers ..... Deborah Wilke
Specialty society services ..... Lanny Hardy
Student loans and scholarships
- applications ..... Julie Hein
- repayments ..... Norma Swenson/ Jane Anderson

Student Section activity ..... Linda Boyd
SMS Holdings Corp
- accounts receivable ..... Marcella Herfel/ Kris Hensen
- accounts payable ..... Kris Hensen
- Lakeside Association Services, Inc. ..... Lanny Hardy/ Kathy Mohelnitzky/Jackie Millar
- Lakeside Administrators ..... Jeanette Edwards
- claim forms ..... Bill Guerten
- printing ..... Dave Conner
- endorsed programs ..... Noreen Krueger/ Lee Johnson
- general ..... Lee Johnson
- insurance premiums ..... Jan McChesney
- premiums ..... Jan McChesney
- SMS Service Insurance Plans ..... Jan McChesney/ Heidi Ness

Super rule update ..... Trish Ramsay

T

Tax problems ..... Sally Wencel
Television ..... Deborah Wilke/ Russell King
Title 18 (Medicare) ..... Trish Ramsay
Title 19 (Medicaid) ..... Trish Ramsay
Tourette Syndrome Physician Guides ..... Julie Hein

U

Utilization review ..... Mary Braham

W

WHCLIP (Wisconsin Health Care Liability Insurance Plan) ..... Mark Adams
Wisconsin Ambulatory Medical Care Survey ..... Mary Barham
Wisconsin Association of Senior Physicians (WASP) ..... Julie Hein
Wisconsin Medical Journal ..... Russell King/ Marlene Scott
Wisconsin Peer Review Organization (WIPRO) ..... Trish Ramsay/ Sally Wencel
WIPRO audits ..... Trish Ramsay
WISPAC ..... Terry Hottenroth/ field representatives
Women's health issues ..... Mary Barham
Worker's compensation ..... Cecilia Geis/ Sally Wencel/Mark Adams

Y

Young Physicians Section ..... Trish Ramsay

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Organization

Street

City State Zip

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To fax your request -- (202) 638-0773

Publications and reprints available

A number of brochures are available from the SMS. Most are intended as patient-education materials on scientific and socioeconomic issues; others are useful as physician-education tools on socioeconomic and legislative topics. Some are available free of charge, while others require a nominal charge. Call the SMS Division of Communications for more information: 1-800-362-9080, or in Madison, 257-6781.

Facts About Malignant Melanoma

Part of the revived Health Watch series, this patient education brochure explains who is most at risk, how to detect and prevent melanoma, and how to conduct a self-examination. Published in 1988.

If You Have a Complaint About Medical Care

This brochure explains the SMS's grievance and peer review system. Published in 1983.

The Liability Crisis in Wisconsin

A patient education brochure that explains why your patients should care about your medical liability costs, what the problem is, and what they can do about it. The emphasis of the brochure is on the value of a cap on non-economic awards. Published in 1989.

Make Yours a Smokeless Pregnancy

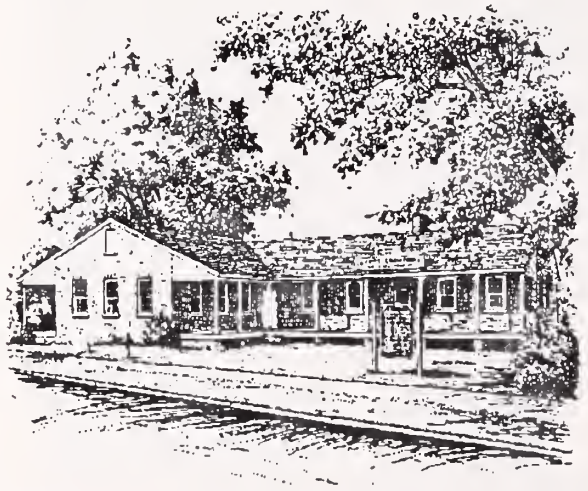
This important brochure drives home the very real dangers to, and effects on, the fetus of smoking during pregnancy. Published in 1980.

Medical Professional Liability Insurance: Claims Made or Occurrence?

This brochure explains for physicians how the policies work, how premiums are established, how coverage is terminated, the limits of liability and how to decide between the types of coverage. The brochure was produced by the Young Physicians Section and is particularly useful for physicians just beginning their practice. Published in 1989.

Occupational Health Guide

This 3-ring binder contains information for medical and nursing personnel in the commercial and industrial setting. One to five copies, $45 each; more than five, $40 each, including postage. Wisconsin residents add 5% sales tax. Make checks payable to: CES Foundation, PO Box 1109, Madison, WI 53701. Payment must accompany the order. A revised edition will be available this fall. Published in 1985.



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10th Anniversary
Saturday & Sunday, July 27-28, 1991

This reconstructed military hospital
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1-800-545-0634

PartnerCare
A poster and brochure aimed at educating elderly low-income patients about this important SMS voluntary Medicare assignment program. Published in 1990. Contact the SMS Division of Medical Policy and Practice for ordering information.

A Physician's Guide to Wisconsin Health Law
This handbook deals with the more important legal and socioeconomic issues affecting the practice of medicine in Wisconsin. The information in this book will help you avoid pitfalls, answer your patients' questions, ask the right questions when you need counsel, and become a more involved and effective voice for the profession. To order, please contact or call *Wisconsin Medical Journal* offices at SMS. Published in 1991.

A Practical Guide to Public Relations
This booklet is designed to assist Wisconsin's county medical societies to enhance their public relations efforts in their own communities. Published in 1988.

Putting the UCR Fee Puzzle Together
Explains what "usual, customary and reasonable" means, how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. The small size of this brochure makes it suitable for enclosure in office statements or for placement in patient reception areas. Published in 1990.

Questions and Answers on Smokeless Tobacco
Part of the revived Health Watch series, this patient education brochure explains smokeless tobacco and its dangers in plain language. Published in 1988.

Responsible Health Care Initiatives
Following 8 months of discussion with business and health care leaders throughout Wisconsin, a comprehensive package of cost containment initiatives was developed by the SMS, Wisconsin Manufacturers and Commerce, Association of Wisconsin HMOs and the Wisconsin Hospital Association. This brochure outlines the group's proposals. Published in 1991.

Rubella-Red Measles
This brochure, which alerts women of the need for pre-pregnancy Rubella immunizations and reminds parents to have their children immunized for red measles, is small enough to include with billing statements as well as distribute in waiting rooms. Published in 1977.

School Health Examination
A guide for physicians and school authorities in establishing a program of school health examinations. Single copy $2 plus 5% sales tax with order. Checks to be made payable to: CES Foundation, PO Box 1109, Madison, WI 53701. Published in 1983.

Some Straight "Dope" on Marijuana
What marijuana is, who uses it, and the hazards–psychological and physiological–associated with its use. Published in 1981.

Speakers Bureau: Committee on Alcoholism and Other Drug Abuse
How to contact Wisconsin physicians willing and able to speak on alcoholism and drug abuse, and the topics they cover, as well as what physicians can and cannot do for actively drinking alcoholics and chemically dependent patients. Published in 1988.

Update REACH: Resource for Education Awareness of Community Health
Examining the changing nature of the public's image of physicians and explaining SMS media policies and programs on current medical issues. Published in 1985.

What's Wrong with Medicare?
Subtitled: "What Every Senior Citizen Needs to Know About Medicare and Mandatory Assignment," this is an important new brochure for physicians' older patients. In easy-to-read type in an easy-to-understand question-and-answer format, the brochure is designed to dispel the current Medicare confusion and mandatory assignment mythology. Published in 1989.

Worker's Compensation
The SMS makes available to physicians several brochures and booklets designed to ease the burden of worker's compensation cases. Titles include: "How to Evaluate Permanent Disability," published in 1987; "Wisconsin Doctors and Worker's Compensation," published in 1987; and "Using the WC-16B for Worker's Compensation," published in 1986. ❑

Physician briefs

Douglas Palmer, MD,* of Mt Horeb, has been named chief of staff at Memorial Hospital of Iowa County. An orthopedic surgeon, Dr Palmer will serve a 1-year term. Dr Palmer has been on the hospital's active medical staff since 1986. He attended medical school at the Medical College of Wisconsin, and completed an orthopedic surgery residency at the University of Illinois-Chicago.

John Lehman, MD, of Highland, has been named to the Memorial Hospital of Iowa County Board of Directors.

Laurence Tempelis, MD, of Burlington, recently joined the Burlington Clinic. An oncologist, Dr Tempelis received his medical degree from the University of Wisconsin Medical School. He completed an internal medicine residency at the

Continued on next page

UW Medical School in Milwaukee and an oncology fellowship at Tufts University School of Medicine.

Greg Schissel, MD, of Devils Lake, has begun duties as a locum tenens physician at the Grantsburg Clinic. A family practitioner, Dr Schissel was a family practitioner for 35 years in Minneapolis, and was affiliated with North Memorial Hospital.

Jim Sargeant, MD, of Arcadia, has recently joined the Arcadia Primary Care Clinic at St Joseph's Hospital. A physician and surgeon, Dr Sargeant had been in private practice at the Park Falls in conjunction with the Flambeau Medical Center. Dr Sargeant received his medical degree from Marquette University and did his residency in surgery at St Joseph's Hospital in Milwaukee.

Vic Sobalewski, MD, of Whitewater, recently joined the Mercy Hospital affiliated clinic in Whitewater. A family practitioner and sports medicine specialist, Dr Sobalewski had been practicing in Philadelphia.

WISPAC and Physicians for Better Government

The Wisconsin Physicians Political Action Committee (WISPAC) is a voluntary, nonprofit organization open to physicians and their spouses. Restricted from making political contributions, the SMS created WISPAC to provide the medical profession an opportunity to become more politically active and effective. WISPAC is governed by a board of directors, traditionally concentrates on state legislative races, and cooperates with the Amercan Medical Political Action Committee (AMPAC) on federal issues.

Physicians for Better Government is a direct giver program, or political conduit, established in 1987 by the SMS. Political conduits differ from political action committees in that contributors retain the right to decide who receives their individual contributions. Physicians for Better Government contributions are deposited in a special account in each contributor's name. No contribution is made to a candidate without the contributor's authorization.

WISPAC and Physicians for Better Government are administered by the SMS Division of Public Affairs, pursuant to state statutes and administrative rules authorizing and regulating these programs. For additional information call 608-257-6781 or 1-800-362-9080.

Contributions may be sent to: Physicians for Better Government/WISPAC, PO Box 2595, Madison, WI 53701.

Suggested membership categories include:

- $200 Sustaining member
  ($100 Physicians for Better Government, $50 WISPAC, $50 AMPAC)
- $100 Sponsor
  ($50 Physicians for Better Government, $30 WISPAC, $20 AMPAC)

Contributions at the above levels authorize PFBG to transfer the amounts shown to WISPAC and AMPAC. If you wish to contribute differently, you may allocate amounts of your choice, per the examples below:

- $50 Physicians for Better Government only
- $50 WISPAC/AMPAC ($30 WISPAC, $20 AMPAC)
- $30 WISPAC only ❑

Esteban R. Guevara, MD,* of Milwaukee, began practice at the Sheboygan Clinic on June 1. An oncologist, Dr Guevara received his medical degree at the Universidad Nacional Autonoma de Mexico and completed his internship at St Francis Hospital in Evanston, Ill, and his residency in internal medicine at Cook County Hospital in Chicago. Dr Guevara completed medical oncology fellowships at Presbyterian St Luke's Hospital in Chicago and at Mount Sinai Medical Center in Milwaukee.

Sue Jennings, MD, of Franklin, recently joined Medical Consultants in Burlington. A general practitioner, Dr Jennings received her medical degree from the Medical College of Wisconsin, and completed an internship at Northwest General Hospital in Milwaukee.

Rod Erickson, MD, of Tomah, recently joined the Lake Tomah Clinic and the medical staff at Tomah Memorial Hospital. A family physician, Dr Erickson received his medical degree from the Medical College of Wisconsin, and completed his residency training at the Family Practice Residency Program in Cedar Rapids, Iowa.

Dennis Luther, MD, of Butternut Lake, will join the medical staff at the Marshfiled Clinic-Park Falls Center in August. An internist, Dr Luther received his medical degree from the University of Pittsburgh School of Medicine. He completed his residency in internal medicine at the University of Reno-Nevada.

Frank J. Cadwell, MD, of La Crosse, has joined the Gundersen/Lutheran medical staff. An internist with a subspecialty in oncology/hemotology, Dr Cadwell received his medical degree from the University of Minnesota Medical School. He completed his residency at Abott-Northwestern Hospital in Minneapolis.❑

Obituaries

Paul J. Ambro, MD, 65, of Kenosha, died Oct 13, 1990, in Kenosha. Dr Ambro was born on Oct 28, 1924, in Milwaukee, and graduated from the University of Wisconsin Medical School-Madison in 1951. His internship was completed at Highland Park General Hospital in Highland Park, Mich. He served in the US Army Air Forces from 1943 to 1945. Dr Ambro had practiced in the Kenosha area from 1953 until his retirement in 1988. He was a member of the American Academy of Family Physicians, the Kenosha County Medical Society, the SMS, and the AMA. Surviving are his widow, Patricia; four sons, Paul, of Kenosha; John, of Sparta; Joseph, of Rochester, NY; and Dr Thomas, of Milwaukee; and two daughters, Ellen Palmer, of St Cloud, Minn, and Alice Pedersen, of Wauwatosa.

Glenn A. Dall, MD, of Elm Grove, died March 9, 1991, in Elm Grove. Dr Dall was born Oct 6, 1922, in Milwaukee, and graduated from Marquette University School of Medicine in 1949. His internship was completed at Milwaukee Hospital. Dr Dall served in the US Army from 1942 to 1946 and in the US Army Medical Corps in 1953 and 1954. Dr Dall was in private practice in the Milwaukee area for 25 years and then was an associate professor of family practice for the Medical College of Wisconsin. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Laverne; and his son, James, and daughter, Christine Sickler, and six grandchildren.

Elmer E. Kern, MD, of Mukwonago, died March 31, 1991, in Waukesha. Dr Kern was born Feb 4, 1914, in Milwaukee, and graduated from Marquette University School of Medicine and served his internship at St Agnes Hospital in Fond du Lac. He practiced in Mukwonago from 1940 until his retirement in 1984. Dr Kern also served in the US Navy from 1943 to 1946. He was a member of the American Academy of Family Physicians, the Waukesha County Medical Society, the SMS, and the AMA. Surviving are his widow, Ruth, and a son, Dr Martin, of the town of Genesee.

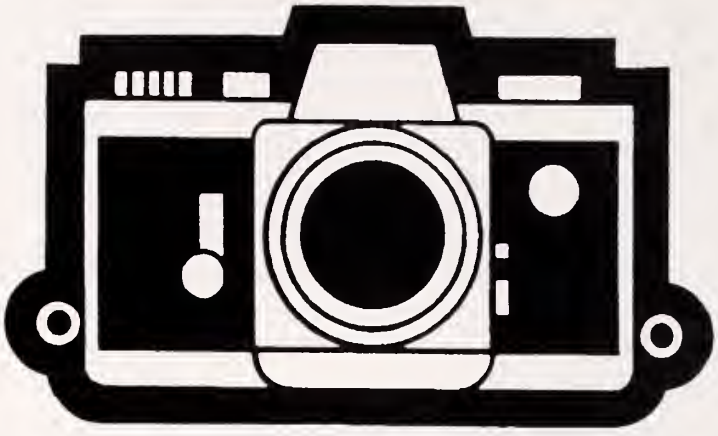
Einar R. Daniels, MD, 84, of Wauwatosa, died April 18, 1991, in Wauwatosa. Dr Daniels was born July 21, 1906, in Milwaukee, and graduated from the University of Wisconsin Medical School, Madison. His internship was completed at Milwaukee County General Hospital. Dr Daniels served in the US Army Medical Corps from 1942 to 1946. He was one of the founders of Harwood Medical Associates in Wauwatosa, and also served as chief-of-staff of the Lutheran Hospital, now part of Sinai Samaritan Medical Center. In 1955, Dr Daniels was given the "Salute of the Year Award" from the Milwaukee Comeback club, an organization of recovered tuberculosis patients. He had been medical adviser since 1942. He served as president of the Milwaukee Academy of Medicine in 1956, and also was a former president of the Wisconsin Chapter of the American Heart Association. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Lorraine; and two sons, Steve, of Milwaukee, and Dr John, of Aralee, Mont.

Mark G. Langenfeld, MD, 46, of Elm Grove, died April 18, 1991, in Milwaukee. He was born Feb 27, 1945, in Fond du Lac, and graduated from Marquette University School of Medicine in 1970. Dr Langenfeld served his internship at St Francis Hospital in Peoria, Ill, and also served as a physician in the US Army Medical Corps. In 1975, he joined the medical staff of Waukesha Memorial Hospital as an emergency physician. He also was the medical director of the Waukesha Fire Department paramedics. In 1985, he was named a fellow of the American College of Emergency Physicians and a Zeit fellow with the Medical College of Wisconsin. He was a member of the Waukesha County Medical Society, the SMS, and the AMA. Surviving are his widow, Jane; one daughter, Amy; his parents, Dr and Mrs Gregory Langenfeld, of Theresa, ad well as two sisters, Judith and Kris, and one brother, Peter.❑

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.

WMJ physician photo contest



Awards: Publication on the cover of the *Wisconsin Medical Journal* and a commemorative plaque, presented at the SMS annual meeting.

Eligibility: The competition is open to members of the State Medical Society of Wisconsin and its Auxiliary only.

Guidelines: A total of three entries in any combination of the following categories may be submitted.

- A doctor's life
- The science of medicine
- The art of healing
- Wisconsin wildlife
- Wisconsin places
- Wisconsin people

Entry in the contest constitutes agreement to allow the entered photographs to be published in or on the cover of the *Wisconsin Medical Journal.* Vertical photos are preferred, but horizontal photos are accepted. Entrants retain all other rights to their photographs.

Entries must be original prints or slides in color or black and white. Prints may be mounted, but not framed, and mount size should not exceed 11x14. Negatives must be available for all prints.

The back of each photograph must bear the photographer's name, address and phone number, and the title—if any—of the photo. Enclose, preferably on a separate sheet, a brief description of where, when and how the photo was taken. If possible, note the make and model of camera and lens used for each photo, film used, exposure settings, and any special equipment. Previously published material may be entered; however, please include the information on when and where the photo has appeared.

The *WMJ* cannot be responsible for entries—so do not send your only copy.

Deadline: All entries must be postmarked no later than February 14, 1992. Send entries to: Photo Contest, *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

House actions on resolutions and reports

Resolution 1 addressed WPS-Medicare regulations regarding physician signatures on dictated office progress notes. The resolve was amended to read: "Resolved, that the State Medical Society of Wisconsin take whatever steps are necessary to change the Medicare requirements to allow the physician the choice of signing typed progress notes in the physician's office setting." **Action:** adopted as amended.

Resolution 2 concerned the OBRA '90 provision that eliminates Medicare reimbursement for EKG interpretations, and called for the SMS to go on record in opposition to this provision. **Action:** adopted in lieu of Resolution 46.

Resolution 3 supported legislation to revise the laws of evidence to make explicit that loss of control of a motor vehicle under any condition in and of itself is probable cause for obtaining a blood alcohol level. **Action:** resolution merits further review and was referred to the Board of Directors.

Resolution 4 described the current federal health care regulatory environment and calls for the SMS to reorganize itself as a medical union to bargain for Wisconsin physicians. **Action:** rejected.

Resolution 5 concerned the Medicare prospective payment system and its effect on rural hospitals. The first resolve was deleted and the second resolve was amended to read: "Resolved, that the State Medical Society communicate with the Wisconsin congressional delegation to convey the seriousness and magnitude of existing hospital payment inequalities." **Action:** adopted as amended.

Resolution 6 stated that physicians and other health care personnel should know the HIV status of patients they are treating and requested that the SMS introduce legislation to allow for routine preadmission screening of all hospital patients for HIV. The resolution also suggested that public health techniques used for monitoring other STDs should be employed to assist in AIDS prevention. A sustitute resolution which read: "Resolved, that the State Medical Society continue its efforts through physician publications and the Midwest AIDS Training and Education Center to improve physician understanding of the legalities of treating HIV infected patients," was adopted. **Action:** adopted substitute resolution 6 in lieu of resolution 6.

Resolution 7 requested the SMS to introduce legislation providing for mandatory and binding arbitration in medical malpractice cases. **Action:** referred to the Board of Directors.

Resolution 8 recognized current insurance law, which requires coverage of chiropractic services, and recommended that the SMS seek legislation to make coverage optional. **Action:** rejected.

Resolution 9 concerned usual, customary and reasonable (UCR) limitations used by Surgical Care-Blue Shield. The first and second resolves were deleted and the following resolves substituted: "Resolved that the State Medical Society recognizes the continuing problem of insurance companies failing to pay physicians' charges as submitted," and be it further, "Resolved, that the State Medical Society continue to educate patients about their financial obligations for their care and work with insurance companies and the Office of the Commissioner of Insurance on this issue." **Action:** adopted as amended.

Resolution 10 dealt with the Patients Compensation Fund. **Action:** referred to the Board of Directors.

Resolution 11 recommended that the SMS go on record opposing pesticide and herbicide use whenever appropriate and encouraging public notification when these substances are used. **Action:** referred to the Board of Directors.

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Resolution 12 addressed school cafeteria food and expressed concern regarding the availability of "junk food" on school grounds. Substitute resolution 12, adopted in lieu of resolution 12 read: "Resolved, that the State Medical Society support schools' provision of health snacks and nutritious meals and encourages the Department of Public Instruction to continue its educational and monitoring programs to enhance school food and nutrition programs." **Action:** substitute resolution 12 was adopted.

Resolution 13 proposed that the House of Delegates establish a section for thoracic medicine and that it be organized as an open assembly. **Action:** referred to the Board of Directors.

Resolution 14 concerned staffing levels at the Medical Examining Board and requested increased support staff for the MEB. The Reference Committee on State and National Issues made note that the resolution is identical to the one passed in the 1990 House of Delegates and is already SMS policy. **Action:** referred to the Board of Directors with two additional resolves: "Resolved, that the State Medical Society also seek further corrective legislation to prevent local circuit court appeals and staying of the order for disciplinary action by the MEB," and be it further, "Resolved, that the State Medical Society, under the state of Wisconsin Constitution and the legislature have the appellate court become initial jurisdiction over appeals of decision and actions taken by the MEB."

Resolution 15 proposed to limit to 12 years the term of a delegate or an alternate delegate from the SMS to the AMA. **Action:** rejected.

Resolution 16 dealt with limits on damages for wrongful death. **Action:** referred to the Board of Directors with the suggestion that they move expeditiously to address this issue.

Resolutions 17 and 18 address the waste of medical and Medicare resources due to inappropriate medical care. **Action:** referred to the Board of Directors.

Resolution 19 reviewed the OBRA '90 provisions that limit Medicare reimbursement to physicians who have been in practice for less than 5 years. The first resolve was amended to read: "Resolved, that the State Medical Society of Wisconsin go on record as opposing discriminatory Medicare payment practices to physicians who have been in practice

Reference committees: 1991

Socioeconomic activities
Terry Hankey, MD, Waupaca, chair
John De Giovanni, MD, Prairie du Sac
Paul Steingraeber, MD, La Crosse
Charles Pechous, MD, Kenosha
Jean Loftus, MD, Madison

Scientific activities
Sandra Osborn, MD, Madison, chair
Christina Keppel, MD, Milwaukee
Sally Schlise, MD, Green Bay
Edward Winga, MD, La Crosse
M. Zuhdi Jasser, Wauwatosa (student)
Tom Grau, MD, La Crosse (alternate)

State and national issues
John Ridley, MD, Milwaukee, chair
Patricia Barwig, MD, Milwaukee
Ayaz Samadani, MD, Beaver Dam
Thomas Kidder, MD, Milwaukee
Kevin Flaherty, MD, Wausau

Organization and finances
William Maurer, MD, Marshfield, chair
Robert Madden, MD, Milwaukee
T. Bayard Frederick, MD, Fond du Lac
Philip Happe, MD, Eau Claire
Lee Tyne, MD, Brookfield
Kay Heggestad, MD, Madison (alternate)

Credentials
Paul Wertsch, MD, Madison, chair
George Gay, MD, Cambridge
Carol Young, MD, Milwaukee

Special reference committee on board representation
J D Kabler, MD, Madison, chair
Robert Purtell, Jr, MD, Milwaukee
Susan Turney, MD, Marshfield
John Simenstad, MD, Osceola
Charles Geiger, MD, West Bend
David Weber, MD, Fond du Lac, (alternate)

less than 5 years. The second resolve was amended as follows: "Resolved, that the State Medical Society of Wisconsin supports development of legislative strategies to secure equal Medicare payments for services provided by new physicians." **Action:** adopted.

Resolution 20 recommended that laser surgery be performed only by physicians or other individuals licensed by the state to perform surgical services. **Action:** adopted original resolution 20.

Resolution 21 dealt with developing a code of conduct for peer review. **Action:** referred to the Board of Directors.

Resolution 22 addressed three issues related to drinking and driving. The first resolve concerned increasing the age for zero-tolerance drinking and driving from 19 to 21. **Action:** first resolve referred to the Board of Directors for additional review.

The second resolve requested the Society's support for a zero-tolerance level for drivers of all ages and support for the concept of designated driver programs throughout the state. **Action:** amended second resolve to read: "Resolved, that the State Medical Society reaffirm its present position to support legislation that sets a 0.04 blood alcohol content illegal per se standard for all drivers, consistent with federal mandates for truckers."

Another resolve was added which read: "Resolved, that the State Medical Society support the concept of designated driver programs throughout the state." **Action:** adopted.

Resolution 23 sought to establish a standard hospital application form. Resolution 23 was amended by deleting the word "standard" on line 15 and replacing it with "uniform application," and on line 16, replacing "privileges" with "memberships," so that the resolve read: "Resolved, that the State Medical Society of Wisconsin work with the Wisconsin Hospital Association to develop a uniform application form for use in determining hospital medical staff memberships at Wisconsin hospitals." **Action:** adopted as amended.

Resolution 24 recognized the importance of the Medical Issues Conference and encouraged careful scheduling to optimize attendance. **Action:** referred to the Board of Directors.

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The 1991-1992 SMS Board of Directors. Please see pages 329-339 for biographical information on each director.

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Resolution 25 speaks to reducing medical waste produced by physician offices and hospitals, and proposes that the SMS study methods to reduce all medical office and hospital waste. A substitute resolution: "Resolved, that the State Medical Society urge members to reduce as much as possible medical waste and other office waste in their offices and hospitals and to decrease the use of non-recyclables." **Action:** substitute resolution 25 was adopted in lieu of resolution 25.

Resolution 26 concerned the reporting of domestic violence. **Action:** referred to the Board of Directors.

Resolution 27 dealt with the licensing and certification of Community Based Residential Facilities. **Action:** rejected.

Resolution 28 requested that the president of the United States set a date for a White House Conference on Aging. Resolution 28 was amended to read: "Resolved that the State Medical Society of Wisconsin House of Delegates support a resolution to the American Medical Association to take appropriate steps to encourage President George Bush to set a date for a White House Conference on Aging." **Action:** adopted as amended.

Resolution 29 addressed Medicare reimbursement for home health and nursing home services. The resolve was amended to read: "Resolved, that the State Medical Society of Wisconsin support a resolution to the AMA supporting that organization's continuing discussions with the Health Care Financing Administration to: a) improve Medicare reimbursement to physicians for primary care services, specifically nursing home and home care medical services, and b) institute appropriate and adequate Medicare reimbursement to physicians for case management services." **Action:** adopted as amended.

Resolution 30 called for the state of Wisconsin to comply with the OBRA '89 provision that requires that Medical Assistance recipients be guaranteed access to obstetrical and pediatric care equal to that of other state residents. The resolve was amended to read: "Resolved, that the State Medical Society urge the state of Wisconsin, through administrative and/or legislative action, to comply with all the provisions of OBRA '89 for the benefit of the women and children of Wisconsin." **Action:** adopted as amended.

House of Delegates Nominating Committee: 1990-1991

District 1
Irwin J. Bruhn, MD, Route 1, Box 64-A, Lakeville Rd, Walworth 53184
Jerome W. Fons, Jr, MD, 3734 W Coldspring Rd, Greenfield 53221
James P. Gierahn, MD, 2405 Northwestern Ave, Racine 53404
Robert F. Purtell, Jr, MD, 3316 W Wisconsin Ave, Milwaukee 53208
John D. Riesch, MD, PO Box 427, Menomonee Falls 53051-0427

District 2
Thomas H. Browning, MD, 20 S Park St, Suite 355, Madison 53715-1348, chair
Sandra L. Osborn, MD, 1912 Atwood Ave, Madison 53704
Jeffrey C. Thomas, MD, 3524 E Milwaukee St, Janesville 53546

District 3
Kevin A. Jessen, MD, 1112 Charles Dr, Tomah 54660

District 4
Robert E. Phillips, MD, 1000 N Oak St, Marshfield 54449, secretary

District 5
Kenneth M. Viste, Jr, MD, 100 Stoney Beach Rd, Oshkosh 54901

District 6
Rolf S. Lulloff, MD, 2520 Betty Court, Green Bay 54301

District 7
William A. Smith, MD, 1020 Lakeshore Dr, Rice Lake 54868

District 8
Joseph M. Jauquet, MD, 2101 Beaser Ave, Suite 2, Ashland 54806

Specialty sections
Carl S. L. Eisenberg, MD, 3003 W Good Hope Rd, PO Box 17300, Milwaukee 53217

Resolution 31 requested that the SMS support legislation to allow physicians or legal guardians of foster children to test them for HIV infection and further, that foster parents be informed of the complete health status of children placed in their care. **Action:** referred to the Board of Directors.

Resolution 32 expressed concern regarding state assistance for health care providers in responding to hazardous material emergencies, and offers several specific suggestions to enhance the state's role. **Action:** referred to the Board of Directors.

Resolution 33 was introduced to show support for the soldiers in the Persian Gulf.

The resolution was amended to read: "Resolved, that the State Medical Society of Wisconsin House of Delegates honor those who have served and continue to serve in Operation Desert Storm." **Action:** adopted as amended.

Resolution 34 advocated increased exposure of medical students to family practice, particularly in rural and inner city areas, and that the medical schools enlist the assistance of rural and inner city family physicians in providing this experience. **Action:** first resolve from original resolution 34 was adopted and the second resolve was adopted as amended.

Resolution 35 requested that the SMS support the creation and funding of a comprehensive emergency medical services system plan for Wisconsin. **Action:** referred to the Board of Directors with the request that current Society policy in this area be reviewed and that a consolidated policy be presented for consideration at a later date.

Resolution 36 was introduced to develop a hospital-based domestic violence pilot program. **Action:** referred to the Board of Directors.

DeLore Williams, MD, receives the Directors' Award, the SMS' highest honor, at the 1991 annual meeting.

Resolution 37 requested that the SMS discourage its members from saying "I do" when taking an oath in court. **Action:** rejected.

Resolution 38 dealt with trial lawyer methods. **Action:** rejected.

Resolution 39 concerned President Bush's proposed $23 billion in Medicare spending cuts over the next 5 years, and calls for the SMS, in conjunction with the AMA, to put forth aggressive efforts to prevent such significant reductions in Medicare funding. **Action:** adopted.

Resolution 40 requested that the SMS develop model legislation regarding treatment of alcoholism and mandatory sentencing for drunken driving convictions. Substitute resolution 40, which read: "Resolved, that the State Medical Society review the reasons for repeated drunk driving offenses and recommend any additional system modifications that would help stem repeated drunken driving occurences," was adopted. **Action:** adopted substitute resolution 40 in lieu of resolution 40.

Resolution 41 expressed concern regarding over-the-counter sales of stimulants and appetite suppressants and the potential health risks that they pose to consumers. The resolution was amended to read: "Resolved, that the State Medical Society address the issue of over-the-counter sales of stimulants and purported appetite suppressants and the potential health risks that they pose to consumers, with a goal of developing educational, legislative or regulatory initiatives to avert this threat." **Action:** adopted as amended.

Resolution 42 recommended that the SMS support the AMA Health Access America Plan as the comprehensive program to address the problem of providing health care coverage for the uninsured.The first resolve was amended to read: "Resolved, that the State Medical Society of Wisconsin reaffirm its support for the Health Access America plan and actively work with the Wisconsin congressional delegation to implement the ideas laid out in the AMA proposal." **Action:** adopted as amended.

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Resolution 43 would require the SMS to distribute a compendium of House of Delegates policies to each county medical society for reference purposes. **Action:** rejected.

Resolution 44 dealt with the rules of operation for medical mediation panels. Resolution 44 was amended to read: "Resolved, that the State Medical Society of Wisconsin recommend changes in the rules of the Medical Mediation Panels such that these panels may be more effective in modifying the course of litigation in alleged medical malpractice." **Action:** adopted as amended.

Resolution 45 outlined the current financial condition of the Medicare program, and the increasing reduction in reimbursement, and calls for organized medicine to study alternate free market approaches to funding the program. The resolve was amended to read: "Resolved, that the State Medical Society request that the AMA and the US Congress work together to study and implement free market approaches to health care for Medicare patients and to place the Medicare program on a sound financial footing." **Action:** adopted as amended.

Resolution 46 concerned the OBRA '90 provision that eliminates Medicare reimbursement for EKG interpretations, and called for the SMS to go on record in opposition to this provision. **Action:** adopted Resolution 2 in lieu of Resolution 46.

Resolution 47 dealt with eliminating political action committees. **Action:** rejected.

Late Resolution 48 dealt with the question of fair Medicaid reimbursement. The reference committee recommended a substitute resolve to read: "Resolved, that in order to increase access to obstetric and pediatric care in Wisconsin, particularly in rural and inner city areas, we urge the State Medical Society of Wisconsin to continue to work for a fair Medicaid reimbursement rate," and be it further, "Resolved that we urge the State Medical Society of Wisconsin to continue to work for a Patients Compensation Fund assessment subsidy for high volume Medicaid medical service providers." **Action:** adopted substitute resolution 48.

Late Resolution 49 addressed E-Code use in hospital discharge records, and called for the SMS to go on record as supporting voluntary use of E-Codes by hospital medical record departments for the purpose of evaluating the causes of injury in Wisconsin. **Action:** adopted.

Reports

Report A of the Commission on Continuing Medical Education (CME) reviewed the work of the commission in the areas of CME, remedial CME, and accreditation of hospitals and medical specialties within the state. **Action:** filed.

Report B of the Physicians Alliance Commission discussed policy and positions of the SMS on state and federal regulatory and legislative issues. **Action:** filed.

Report C of the Commission on Mediation and Peer Review summarized the work of the commission in the areas of mediation, peer review, Medicaid auditing, and impaired physicians and reviewed the goals of the commission for the upcoming year. **Action:** filed.

Report D described the activities of the Commission on Public Information during the past year to increase substance abuse awareness by youth, increase the number of physician-citizen of the year award recipients and other efforts to educate the public on medical issues. **Action:** filed.

Report E reviewed the work of the editorial board of the *Wisconsin Medical Journal* over the past year, including the Board's effort to enhance the standards of scientific publishing, increase coverage of socioeconomic and legislative issues, and to develop and implement alternatives to the Blue Book and membership issues. **Action:** filed.

Report F of the Committee on Aging, Extended Care Facilities and Home Health Care reviewed the work of the committee over the past year concerning new federal regulations governing physician and nursing responsibilities in nursing homes and health care agencies, patient resuscitation within nursing homes, testing of elderly drivers and more. **Action:** filed.

Report G outlined the work of the Committee on Alcoholism and Other Drug Abuse including the issue of tobacco-free environments in hospitals and physician's offices, state insurance regulations concerning mental health and alcoholism and other drug abuse and related legislation. **Action:** filed.

Report H of the Committee on Environmental and Occupational Health outlined the committee's work over the year including medical waste disposal issues and revisions to the Occupational Health Guide. **Action:** filed.

Report I reviewed the work of the Committee on Maternal and Child Health and its subcommittee on maternal mortality. The committee addressed a number of issues including teenage pregnancy and school-based clinics, goals and objectives for maternal and child health contained in the state's public health plan, and drug and alcohol

abuse among pregnant women. **Action:** filed.

Report J of the Committee on Medicine Religion and Ethics highlighted the topics of genetic engineering and physician-assisted suicide, two of the many issues covered by the committee. In addition, the following policy was adopted: "Resolved, that the State Medical Society sponsor a forum for the discussion of medical ethics at its annual meeting," and be it further, "Resolved, that the title of the Committee on Medicine, Religion, and Ethics be reviewed." **Action:** adopted.

The Charles Knight Strings provided part of the annual meeting entertainment.

Report K of the Mental Health Committee discussed the committee's concern over the confidentiality of private patients' medical records in the certification of outpatient psychotherapy clinics. **Action:** filed.

Report L discussed the work of the Committee on Safe Transportation over the past year in the areas of testing elderly drivers for driving privileges, review of the state public health plan particularly regarding promoting safety belt use, pediatric injuries in pick-up trucks, alcohol and drug use in heavy truck crashes and the effect of epilepsy or diabetes on the risk of automobile crashes. **Action:** filed.

Report M of the Committee on Health Care Financing and Delivery discussed the committee's review of issues concerning the financing of health care services. The committee closely followed the activities of the Office of Health Care Information (OHCI) and recommended format options for the OHCI Physician Inpatient Discharge Data Report. **Action:** filed.

Report N of the Medical Liability Committee discussed issues considered by the committee including alternative approaches to birth-related injuries and broader financing mechanisms in the medical liability arena. **Action:** filed.

Report O of the Wisconsin Nurses Association/SMS Liaison Committee discussed issues addressed by the committee including Medicaid and Medicare reimbursement for nurse practitioners and development of an Area Health Education Center. **Action:** filed.

Report P of the PartnerCare Working Group discussed the passage of Act 294 in which the Legislature recognized the value of the SMS' voluntary Medicare assignment program and provided state resources to help promote the program to eligible Wisconsin citizens. **Action:** filed.

Report Q of the Medicare Medical Policy Advisory Group discussed the group's role as the reviewing body of Medicare policy and its responsibility to provide advice on current medical practice related to Medicare coverage and medical necessity issues. **Action:** filed.

Report R of the secretary detailed the major SMS accomplishments over the year. The secretary was commended for 5 years of fine leadership. **Action:** filed.

Report S of the Wisconsin delegation to the AMA highlighted the federal issues that the AMA took positions on and detailed the Wisconsin resolutions introduced at the annual meeting. **Action:** filed.

Report T of the Board of Directors was considered in several segments and outlined the amendments to the strategic plan and 1992 dues recommendation, 1990 House of Delegates resolutions 11 and 14. Report T also discussed the SMS Task Force on Relationships Between Medical Schools and Medical Community. **Action:** adopted amendments to the strategic plan and 1992 dues recommendations; adopted portion of Report T pertaining to appointing at least one Board member liaison to each committee and commission in lieu of 1990 House of Delegates resolution 11; adopted portion of report concerning recommending modifications to the election process for directors in lieu of 1990 House of Delegates Resolution 14. The remainder of Report T was filed.

Report U is the Board of Directors report. The report highlighted the

Continued on next page

medical liability efforts and the efforts to establish "smoke free" environments in hospitals and physician's offices. **Action:** adopted policy to establish "smoke free" environments in hospitals and physician's offices and filed the remainder of the report.

Report V of the Board of Directors outlined several items including a recommendation that the SMS seek changes to the Wisconsin statutes mandating insurance coverage for mental health, alcoholism and drug abuse services; reaffirmation of its policy on increases in the 1991-1992 Medical Assistance budget; recommended approval of a package of health care cost containment initiatives proposed jointly by the SMS/Wisconsin Manufacturers and Commerce/Wisconsin Hospital Association Cost Containment Discussion Group; and reviewed the 1990 House of Delegates approval of Resolution 16. **Action:** adopted. Report V also reported on a number of items including practices issues relating to physician assistants and nurse practitioners, formation of the SMS Task Force on Quality Assessment and Implementation of Practice Parameters, and the activities of the OHCI. **Action:** filed.

Supplemental Report V of the Board of Directors discussed recent developments in the data gathering activities of the state Office of Health Care Information. To date, the statutorily created office has gathered only information on hospitals and ambulatory surgery centers. In 1992, the Office is mandated to begin to collect, analyze and disseminate health care information on other health care providers, including physicians. The Board considered the nature and source of such information and recommended that: the SMS not oppose the collection and publication of data on physician qualifications and credentials which is already publicly available; that the SMS strongly oppose collection of charge data from physicians' offices and support the collection of data from insurance companies as the best and most appropriate source; and that the SMS continue to express its ardent opposition to physician assessments as the funding source for OHCI's data collection on physicians. **Action:** Adopted Board's position on the Office of Health Care Information. A second item in **Supplemental Report V** addresses the recommendations of the Wisconsin Health Care Forum on solutions to the health care problem of the uninsured in the state. **Action:** adopted.

Report W of the Board was considered in several segments and outlined broadening the statutory definition of health care worker to include emergency medical technicians, firefighters, police officers, and Good Samaritans; recommending statutory change to "permit court ordered, involuntary phlebotomy or obtaining of other body fluids for the purpose of HIV testing after a health care worker has obtained a certifiable significant exposure, if a specimen of the source patient's blood or other body fluid is not otherwise available, and if the source patient will not consent to being tested"; and refraining from endorsing 1990 House of Delegates Resolution 22 regarding medical waste disposal. **Action:** adopted each segment.

Supplemental Report W outlined a policy regarding testing of elderly drivers. The resolve read: "Resolved, that the State Medical Society continue to support the Department of Transportation's current emphasis on evaluating the functional ability of impaired drivers and of elderly drivers; encourage older drivers to take special driver training courses which may allow them to receive premium discounts; encourage the Department of Transportation to provide more direction to physicians who evaluate the driving abilities of senior citizens. This could be accomplished by the development of a "certificate of examination" to assess functional driving skills of the older driver, similar to the DOT forms for persons with organic heart disease, epilepsy or diabetes. Currently, no such practical guidelines exist either nationally or in Wisconsin; and encourage the Department of Transportation to assess biennially the driving skills of drivers age 80 and over." **Action:** adopted substitute resolution. The House also received reports from the Blue Ribbon Task Force on Alternatives to the Tort System and the Task Force on AIDS. **Action:** filed.

Report of the Special Reference Committee on Board Representation

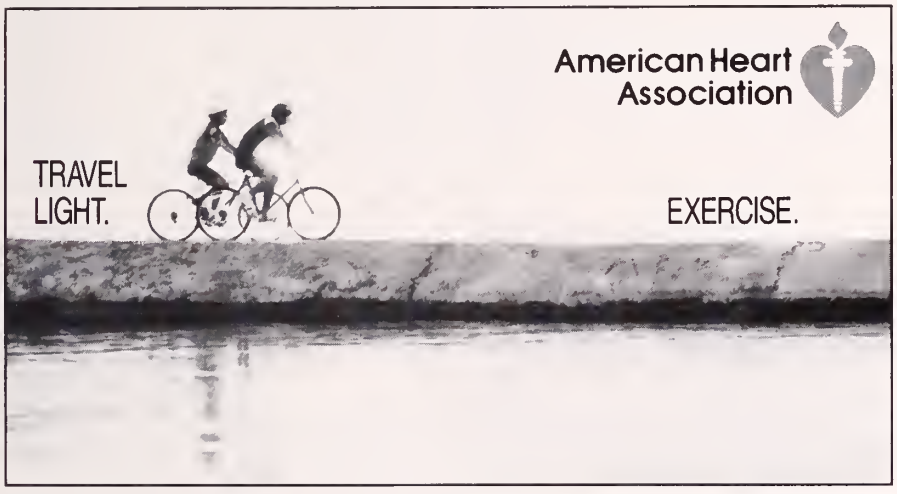
On April 27, 1990, the House of Delegates passed Resolution 26 which called for a task force to be appointed by the speaker of the House of Delegates consisting of representation from each of the eight Board districts. The task force was charged with reviewing and studying the current and proposed district representation on the SMS Board of Directors. A recommendation was to be made to the House of Delegates at its 1991 meeting for an equitable solution to representation on the Board of Directors based on proportionate representation of county medical societies in each district and consideration of an alteration of the district boundaries based on medical practices, referral patterns in regions, physician population, along with other geographic considerations if necessary to accomplish this purpose. Most of the testimony centered on reduced representation that would come about with the proposed reduction of the size of the Board. **Action:** rejected.❑

SMS annual meeting assists food bank

THE 1991 SMS ANNUAL MEETING was the first Wisconsin convention in the national "Network for the Needy" to donate prepared food to Second Helpings, a program of the Second Harvesters of Wisconsin Food Bank. Second Helpings distributed 228 pounds of food, contributed by the SMS, to charitable feeding programs in the Milwaukee area April 19 and 22, 1991. The food was prepared by the MECCA, the Wyndham Hotel and Lee Johns Catering of Waukesha.

"This is a natural extension of the work of the Medical Society's members," Gwen McLean, Second Harvesters general manager, said in a press release. "Physicians take up the practice of medicine because they care about people, and this is one more way they can express that feeling."

The SMS is a member of the Professional Convention Management Association, which has led the national "Network for the Needy." PCMA members are asking that unserved, prepared food left over at the end of conventions be donated to charitable programs such as Second Helpings. ❑



Hometown radio program spreads the word

Twenty-one Wisconsin physicians participated in the Hometown Radio program during the SMS 1991 annual meeting in Milwaukee, April 18-20.

A report released by the News Radio Network indicated that 140 radio stations across the state broadcast the 59-second interviews to each participating physician's local radio station. Actual airplays, including multiple usage by various stations, totalled 78 story broadcasts.

The Hometown Radio program was developed this year by the SMS Commission on Public Information and is designed to give participating physicians the opportunity to speak to the public, via radio, on a variety of issues such as PartnerCare, rural health care, the uninsured and underinsured, managed care issues and the rising cost of medical education.

"The program was very successful and attracted a lot of media attention," said Irwin Bruhn, MD, of Walworth, commission chair. "It gave the physicians who participated an opportunity to vocalize their opinions on many major medical issues facing today's physician, and ultimately, their patients." ❑

Joseph J. Mazza, MD, won the 1991 Erwin R. Schmidt Interstate Teaching Award. *See page 420.*

HOUSE OF DELEGATES: 1991

State Medical Society of Wisconsin

Speaker Richard G. Roberts; Vice Speaker Kenneth I. Gold

County Medical Society	Delegate	Alternate
FIRST DISTRICT		
KENOSHA	James L Concannon	Roman Bilak
	Kevin J Fullin	Ramanuja Rao Manda
	Charles E Pechous Jr	Angelina M Montemurro
	Clifton E Peterson	Michael Zeihen
MILWAUKEE	Albert H Adams	Dale E Bauwens
	Francis I Andres	Fredrik F Broekhuizen
	William H Annesley Jr	Robert P Cronin
	Mark R Aschliman	Andrea L W Green
	Patricia M Barwig	Nora A Janjan
	Donald R Beaver	Jeffrey M Jentzen
	John T Bjork	Susan L Kaehler
	Jeffrey J Butler	James P Maney Jr
	John E Cordes	Muni H Patel
	Donna D Davidoff	Burton A Waisbren
	James D Dolan	David E Weissman
	Gerald J Dorff	45 Vacancies
	Jerome W Fons Jr	
	Peter S Foote	
	Reynaldo P Gabriel	
	Lucille B Glicklich	
	Gerald G Govin	
	Stephen W Hargarten	
	Donald P Hay	
	Harold A Jacobsohn	
	Raymond R Johnson	
	Brian W Kennedy	
	Christina C Keppel	
	Thomas M Kidder	
	Stanley A Korducki	
	Vijay V Kulkarni	
	George M Lange	
	Anthony J Linn	
	Vincent G Lubsey	
	Robert F Madden	
	Raul Mateo	
	James A Means III	
	Dean D Miller	
	John P Mullooly	
	Andrew A Pandazi	
	Robert F Purtell Jr	
	Marcia J S Richards	
	John E Ridley III	
	Roger L Ruehl	
	Thomas L Schlenker	
	George R Schneider	
	Paul J Sienkiewicz	
	William L Treacy	
	Frank H Urban	
	Wess R Vogt	
	James P Volberding	
	Gerald W Wadina	
	Jeffrey M Weber	
	John E Whitcomb	
	DeLore Williams	
	Carol E Young	
	5 Vacancies	
OZAUKEE	Arthur B Conrad	Robert A Pfeffer
RACINE	Victoriano A Baylon	Dennis E Feider
	James P Gierahn	Joan L Milott
	Kenneth J Pechman	David R Zeman
	Gregory A Shove	3 Vacancies
	Raymond E Skupniewicz	
	William H Stone	
WALWORTH	Irwin J Bruhn	Edsel G Doreza
WASHINGTON	Charles S Geiger Jr	William J Listwan
	Michael C Reineck	Thomas E Looze
WAUKESHA	LaVern H Herman	Brian A Chapman
	Charles E Holmburg	Terrence N Hart
	Timothy G Mc Avoy	Karin Kultgen
	G Daniel Miller	Julie N Larsen
	Michael G O'Mara	Kraig E Lorenzen
	John D Riesch	Dean L Martinelli
	Jay F Schamberg	Matthew A Meyer
	James A Stadler II	John R Park
	Lee M Tyne	Gwendolyn Tanel
	Vacancy	Vacancy

County Medical Society	Delegate	Alternate
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	Robert T Cooney	Martin L Janssen
DANE	S Craighead Alexander	James E Engeler Jr
	Adam H Balin	Judith N Green
	Gary R Bridgwater	Janet B Johansson
	Thomas H Browning	Thomas B Kloosterboer
	Dolores A Buchler	Robert A Mc Donald
	Raymond W M Chun	Paul A Mc Leod
	Andrew B Crummy Jr	Kathryn P Nichol
	Peter L Eichman	Joseph F Sackett
	Kenneth Felz	John K Scott
	Kay A Heggestad	Nancy J Selfridge
	Susan N Isensee	Roland J Vega
	Kay E Jewell	John D Wegenke
	J D Kabler	Richard O Welnick
	William L Kopp	Ronald D Wenger
	Richard D Lindgren	9 Vacancies
	Bradley L Manning	
	Bernard F Micke	
	Sandra L Osborn	
	Robert B Shapiro	
	Richard L Staley	
	Benton C Taylor	
	Marc D Tumerman	
	Paul A Wertsch	
DODGE	Ayaz M Samadani	M Ahmad Ali
GRANT	Charles L Steidinger	Vacancy
GREEN	Jan E Erlandson	William E Hein
	James C Pollock	David C Riese
IOWA	Harald P L Breier	Timothy A Correll
JEFFERSON	George L Gay Jr	Michael A Grajewski
LAFAYETTE	Robert J Bernardoni	Lyle L Olson
RICHLAND	James J Tydrich	Thomas L Richardson
ROCK	Paul F Durkee	Ronald K Bowers
	Jordon Frank	Leland J From
	Larry M Ojeda	Diana L Wright
	Jeffrey C Thomas	2 Vacancies
	Kathleen M Wick	
SAUK	John A De Giovanni	Donald W Vangor
THIRD DISTRICT		
CRAWFORD	Michael S Garrity	Randall J Kieser
JUNEAU	Vernon M Griffin	David M Hoffmann
LA CROSSE	Arthur G Barbier	William A Agger
	Alcee J Jumonville	Thomas J Grau
	Thomas P Lathrop	Michael H Mader
	Paul H Steingraeber	James E Novotny
	Edward R Winga	Benjamin C Wedro
	Robert S Witte	Vacancy
MONROE	Kevin A Jessen	Edward O Lukasek
TREMPEALEAU-JACKSON-BUFFALO	Jeffrey K Polzin	Elmer P Rohde
VERNON	Timothy J Devitt	Mark H Andrew

County Medical Society	Delegate	Alternate
FOURTH DISTRICT		
CLARK	Bahri O Gungor	Alfred R Talens
FOREST	Burton S Rathert	E Frank Castaldo
LANGLADE	Michael J Reinardy	James O Moermond Jr
LINCOLN	Orlando M Francisco	Paul A Thompson
MARATHON	Kevin T Flaherty William R Owen Gerald H Schroeder Vacancy	Kathy P Belgea Norman F Deffner Joel R De Koning Thomas O Miller
ONEIDA-VILAS	Paul W Grotenhuis Bruce F Hertel	William E Raduege Vacancy
PORTAGE	Daniel L Brick	Robert J Jaeger
PRICE-TAYLOR	Michael A Haase	William E Yanke
WOOD	Michael J Kryda William J Maurer Michael P Mehr Robert E Phillips Homer H Russ Charles C Sorensen John E Thompson Vacancy	Ali K Choucair Ade R Dillon W Bruce Fye Louis C Hacker Mario V Ponce Theodore A Praxel 2 Vacancies
FIFTH DISTRICT		
CALUMET	William E Hannon	Badri N Ganju
FOND DU LAC	Brian C Christenson Elizabeth T Sanfelippo David R Weber	K Alan Stormo Jeffrey A Strong Vacancy
GREEN LAKE-WAUSHARA	Alan L Taber	Jeffrey J Carroll
OUTAGAMIE	Henry Chessin Charles F Dungar David R Finch Peter V Podlusky Vacancy	George A Behnke 4 Vacancies
WAUPACA	Joseph W Weber	Lloyd P Maasch
WINNEBAGO	George W Arndt James L Basiliere Gerald A Gehl Thomas J Luetzow Johan A Mathison Kevin F Quinn	James E Cauley Albert L Fisher Jr Michael G Tresp 3 Vacancies
SIXTH DISTRICT		
BROWN	James M Berner Robert K De Mott Stewart W Gifford James T Jerzak Rolf S Lulloff Edwin S Watts 2 Vacancies	Bruce C Bressler Kenneth M Kubsch Wesley E Mc Neal 5 Vacancies
DOOR-KEWAUNEE	John J Beck	Michael R Mc Fadden
MANITOWOC	Edward J Barylak Joseph C Di Raimondo	Thomas K Perry Joseph E Trader
MARINETTE-FLORENCE	John E Kraus	Kenneth H Yuska
OCONTO	James J Wallace	William J Wittman
SHAWANO	Ronald L Harms	Vacancy
SHEBOYGAN	Roger G Klettke Kevin S Myers James R Pawlak	John T Livermore Wendelin W Schaefer James L Weygandt

County Medical Society	Delegate	Alternate
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	James F Maser Donald E Riemer	Douglas J Raether William A Smith
CHIPPEWA	Caesar R Gonzaga	Vacancy
EAU CLAIRE-DUNN-PEPIN	Steven G Brown Philip J Happe Daniel F Johnson Henry J Simpson Vacancy	Robert J Fabiny Edgar O Hicks 3 Vacancies
PIERCE-ST. CROIX	Joseph E Powell	James R Beix
POLK	John O Simenstad	William W Young
RUSK	Douglas M De Long	Vacancy
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	Charles R Longstreth	John C Oujiri
DOUGLAS	Robert L Sellers	Vacancy
SAWYER	Lloyd M Baertsch	Paul Strapon III
SECTIONS	**Delegate**	**Alternate**
Allergy & Clinical Immunology	Marshall E Cusic	Robert J Kriz
Anesthesiology	Warren J Holtey	Gregory A Felsheim
Cardiology	A Daniel Harbin	Robert M Green
Dermatology	Joel E Taxman	Nyles R Eskritt
Emergency Medicine	Premal M Joshipura	Vacancy
Family Physicians	Terry L Hankey	Thomas H Peterson
Foreign Medical Graduates	Carlos A Jaramillo	Morgan E Warffuel
Hospital Medical Staff	Stephen R Peters	Louis R Pfeiffer
Internal Medicine	Susan L Turney	Richard A Dart
Medical Faculties	Vacancy	Manucher J Javid
Medical Students	M Zuhdi Jasser	Donald J Anderson
Neurology	Gamber F Tegtmeyer Jr	R Clarke Danforth
Neurosurgery	Glenn A Meyer	S Marshall Cushman Jr
Obstetrics-Gynecology	Charles A Hammond	Michael A Schellpfeffer
Ophthalmology	M Thomas Chemotti	Gregory P Kwasny
Orthopedics	James A Rydlewicz	James H Langenkamp
Otolaryngology	Glenn M Seager	Thomas W Grossman
Pathology	Ronald R Martins	Raymond C Zastrow
Pediatrics	Carl S L Eisenberg	Vacancy
Physical Medicine & Rehabilitation	Ram Parvesh Bhala	Keith B Sperling
Plastic Surgery	Harvey M Bock	Terrence J Wilkins
Preventive Medicine	Vacancy	Jane K Sliwinski
Psychiatry	Rudolf W Link	Pauline M Jackson
Radiation Oncology	Sally M Schlise	Robert H Greenlaw
Radiology	Timothy T Flaherty	Vacancy
Resident Physicians	Jean M Loftus	Vacancy
Surgery	James P Quenan	Louis C Bernhardt
Urology	Stuart W Fine	Charles W Troup
Young Physicians	Gary L Bryant	T Bayard Frederick

Presidential report

The presidential medallion: a symbol of strength

GOOD EVENING, I am Dr Roger von Heimburg, and I am joined on the stage tonight by the chair of the SMS Board of Directors, Dr Richard Ulmer; my successor and the SMS president elect, Dr Kim Hetsko; the SMS auxiliary president Betsy Yao, and her successor, the auxiliary's president, Betsy Yao; and her successor, the auxiliary's president elect, Sandra Kontra. We would like to extend a warm welcome to each you. As president of SMS during the past 12 months, I have received a great many honors, but few compare with the privilege of saluting the special guests with us tonight.

First, I would like to welcome the SMS Board of Directors. Never have I worked with a finer group of people nor encountered a more dedicated group of professionals. Ladies and gentlemen of the board, would you please stand be recognized. Thank you, you may be seated.

Next, please join me in recognizing the SMS delegation to the AMA. The federation of medicine is only as strong as the ties among its various parts, and our delegation is one of the strongest in the nation. The physicians of Wisconsin can find great peace of mind in knowing that it is this group of illustrious individuals that represents their interests at the AMA. Delegation members, would you please stand and be recognized. Thank you.

We also have several dignitaries from home and abroad visiting with us tonight, and I would like to acknowledge them as well. Please stand briefly as I call your name. Dr Jerome Eckrich, Jr, president of the South Dakota State Medical Association; Dr Susan Hershberg Adelman, president of the Michigan State Medical Society; Dr Michael Mellinger, president of the Indiana State Medical Association; Dr Robert Reardon, president elect of the Illinois State Medical Society; Mary Hanson, from the AMA auxiliary; Marlene Cummings, secretary of the Wisconsin Department of Regulation and Licensing, and her guest, Patrick Braatz; Ann Haney, from the Wisconsin Division of Health; David Klauser, from the Wisconsin Office of Health Care information; Dr Mowat Waldren, Jr, from the Wisconsin Medical Examining Board; Thomas Gazzana, from Blue Cross and Blue Shield United of Wisconsin, and Robert Wood, from Wisconsin Physicians Service.

Finally, I would like to acknowledge my family, all of whom have stood by my during a very busy presidential year.

Welcome all.

All of that brings us to a moment I do not relish: the moment I bid you farewell and my presidential term comes to an end. When the presidential medallion was first hung around my neck last April, I knew its weight would not be easy to bear. In this small token was the weight of the immense trust you and your fellow society members had placed in me, and the weight of my responsibility to you. In this medallion is the weight of the president's obligation to the current and future medical professions, and to the health of Wisconsin's current and future residents, for the issues facing the wearer are as critical as they are complex. In this symbol of leadership resides the weight of honorable reputation created by the 134 illustrious physicians who have worn it before me.

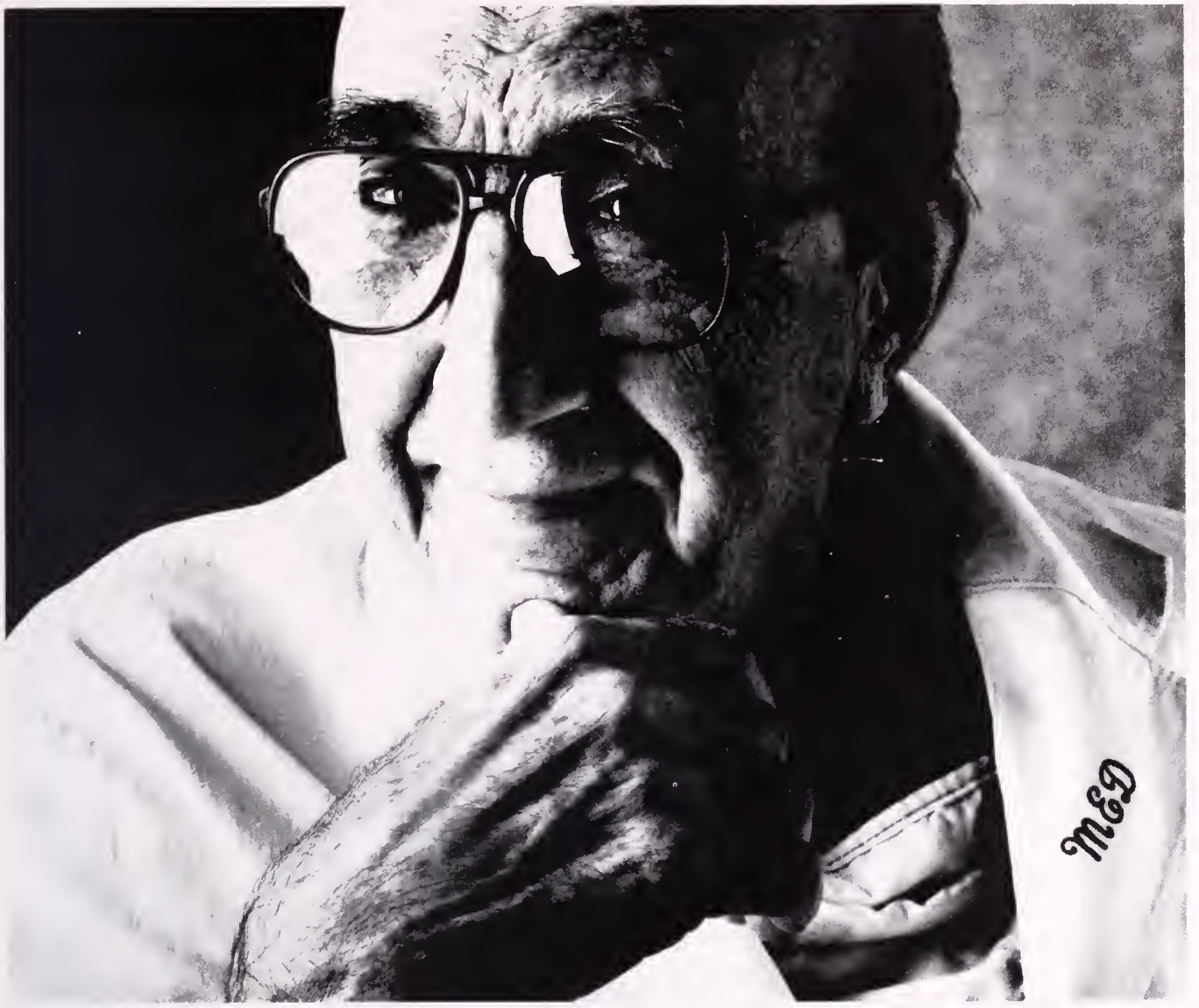
Roger L. von Heimburg, MD

Fortunately, the medallion also is a symbol of strength. There is strength in the character of my predecessors and in the historic prestige of the society. There is strength in the honor you bestowed on me when you elected me president, and in the help and encouragement so very many of you have graciously provided me. And there is strength in knowing that, together, we have fulfilled our obligations to our patients, to our society and to our profession.

Thank you, ladies and gentlemen of medicine. For the trust, for the assistance, for the highest of honors, thank you.❑

HEART DISEASE.
We're Making a Difference.
American Heart Association

Join Dr. DeBakey.



Join The AMA.

"This is a time when we need a unifying force in the medical profession very badly.

"As a member of the AMA, I'm part of an organization that's involved in my life work and through it, I feel I have a relationship with other doctors. Together, we're all working toward the improvement of the medical profession and our relationship with our patients. And that's what the American Medical Association is all about."

Join Dr. Michael E. DeBakey, Chancellor and Chairman, Department of Surgery, Baylor College of Medicine, in the AMA. Call this toll-free number now.

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American Medical Association

Address of the president elect

Building access to quality medicine

WELCOME, AND THANKS to all of you dear colleagues, co-workers, friends and family for attending this evening.

As I told the SMS House of Delegates last year, shortly after I was elected, I am indeed proud to be a physician, I am proud to be a part of the great American medical profession, and I look to the future with optimism.

As we move further into the 1990s, however, Wisconsin medicine and American medicine are faced with the challenges of building better access to quality medical care in the face of what are perceived as dwindling financial resources.

We should remind ourselves how lucky we are to be physicians and to know that sense of accomplishment when we succeed in alleviating suffering in people with as yet incurable problems. The demand for our services also provides us with unique job security and, after many hours of work, comfortable incomes.

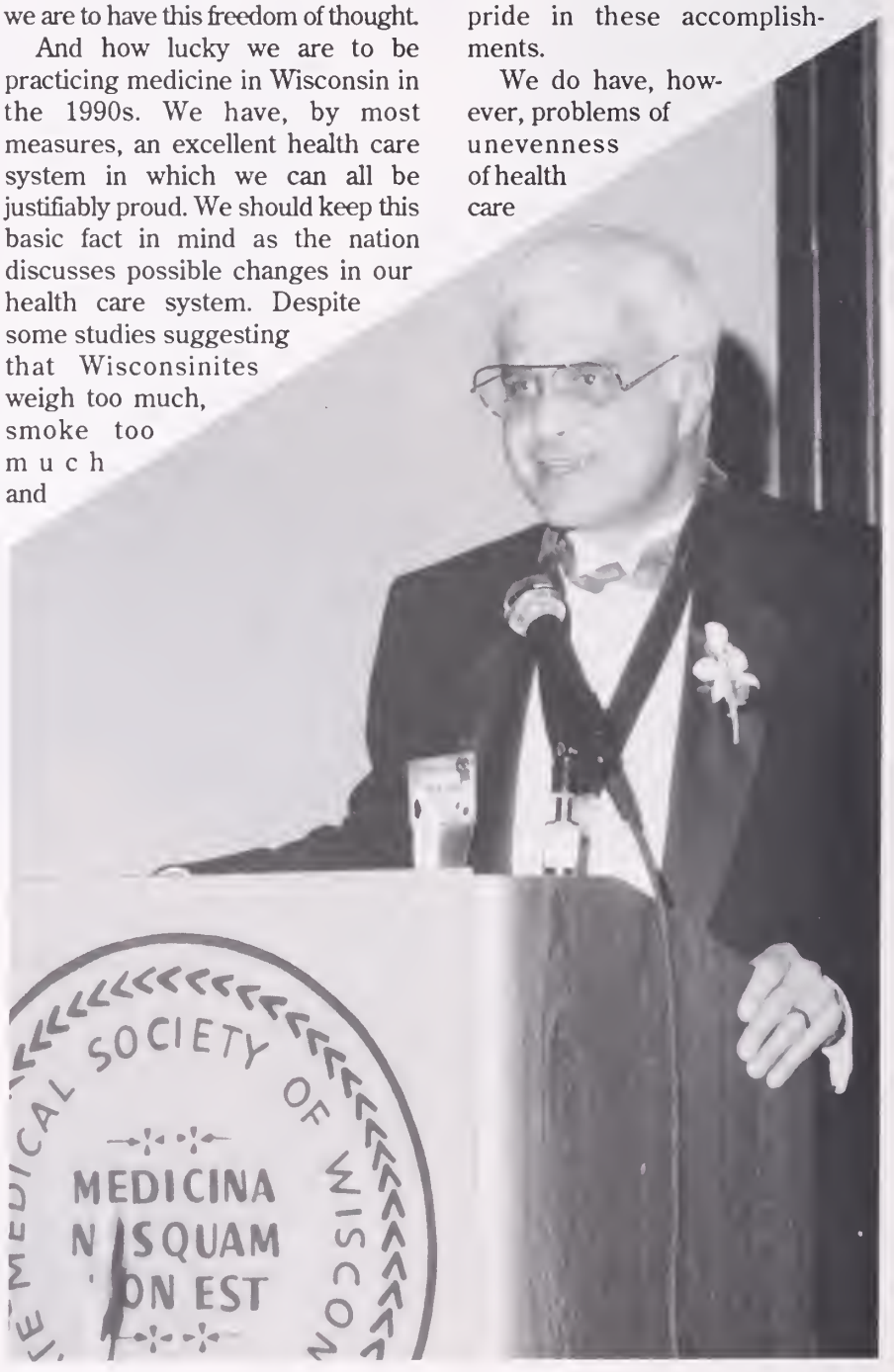
We should remind ourselves how lucky we are, too, to be Americans. We have the freedom to make choices, to pursue careers of our own choosing and to participate in a pluralistic society invigorated by the vitality of many differing ideas and viewpoints.

My wife, Terry, and I had an opportunity to review these important freedoms of thought, which we often take for granted, while visiting eastern Czechoslovakia last fall. This visit was less than a year after the velvet revolution had overthrown 45 years of imposed Communist rule.

We travelled to areas not frequented by tourists in Slovakia, not far from the Russian border, as we chased down some of my ancestral roots. As one of my newly found distant relatives recently wrote in a letter, "Goods are scarcer and more expensive, but this is of little importance as now we are able for the first time in many years to express our thoughts. Thank God." How lucky we are to have this freedom of thought.

And how lucky we are to be practicing medicine in Wisconsin in the 1990s. We have, by most measures, an excellent health care system in which we can all be justifiably proud. We should keep this basic fact in mind as the nation discusses possible changes in our health care system. Despite some studies suggesting that Wisconsinites weigh too much, smoke too much and drink too much alcohol, Wisconsin has one of the longest average life expectancies lowest infant mortality rates in the country. We should take pride in these accomplishments.

We do have, however, problems of unevenness of health care



Cyril M. "Kim" Hetsko, MD, the 1991-1992 SMS president, delivers his address at the 1991 annual meeting.

here in Wisconsin. At least seven of 72 counties in this state have no obstetric services available at all. Much higher infant mortality rates exist in the inner-city areas of Milwaukee; and the closing of many downtown Milwaukee hospitals has left only one hospital remaining–and that one is needing an infusion of government funds.

A conflict has arisen in this state, and across the nation, between the increasing costs of health care and the perception of diminishing resources available to pay for them. Health care costs have been increasing in excess of the consumer price index and, as we all know, taking a bigger percentage of the gross national product.

Perhaps, however, our health care costs should be increasing. Medicine is often given the responsibility of treating those injured or left in need of care by the problems of American society. These include drug abuse, violence (including handguns, assaults, murders, rapes), unwed teenage mothers, and the love of the automobile while combined with alcohol.

Additionally, the graying U.S. population needs more care as it gets older. Various health economists have suggested that perhaps more of the GNP should be going to health care. This is especially true when we consider that currently 12% of the GNP is allocated to health care, and some 23% goes to alcohol, tobacco and entertainment. Clearly, the quantity of medical care has to increase with these problems, and the percentage of GNP occupied by the health care system may well have to increase, even putting aside new technologies and new therapies.

As we strive toward the goal of providing quality health care at as reasonable expense as possible, it is time for us all to exit the greedy "me generation" of the 1980s, and to enter a new era of recommitment to individual contributions for the public good.

Also, with the recent examples of Eastern Europe and the American examples of Amtrack, the postal service, Medicare and Medical Assistance, we must be wary of more centralized government control which stifles original thought, inhibits innovation and leads to misallocation of resources.

Everyone says that health care costs are someone else's responsibility and that someone else should pay. All of us tend to be caught up in the phenomenon of pointing elsewhere rather than acknowledging that all of us, regardless of the original causes of the problem, have a role to play in building upon what we have to develop a system that works for us all.

As the late Sam Rayburn once said, "Any jackass can kick in a barn door, but it takes a carpenter to build one."

I would like to challenge the various key players to roll up their sleeves and get to work building a barn door that opens for us all.

Challenge to physicians

I challenge physicians to embrace the basic tenets of our profession.

By the profession we have chosen, we bought into a special set of obligations. These obligations find their roots in the Hippocratic Oath. We do have special skills, and we are obligated to both continually sharpen them and train other physicians in them. And we occupy a special place in that we are admitted into the most intimate part of people's physical and emotional lives. In this, we do have a special obligation to give back. And, though counter to a predominant ethic in American popular culture today, this "giving back" is in itself a reward. I challenge physicians to not give this up.

Wisconsin physicians have a tradition of assuring that no person goes without health care because of financial or other concerns. Programs such as ShareCare, WisconCare and PartnerCare, participation in Medical Assistance, and the numerous unsung individual acts of compassion and charity stand as testament to this. I challenge physicians to renew this commitment and to continue combining the best of science and the best of compassion.

Yes, medicine does have a business side that cannot be neglected. But we physicians must remember that the business of medicine must empower the caring of medicine, and that the business of medicine must never come before the art and science of medicine.

Unfortunately, we are all subjected to greater public scrutiny because of the greed or excess of a few in our profession. This leads to public distrust and the popular notion that our profession cannot keep its own house in order. Our challenge is to renew our efforts. As physicians, we can and should heal ourselves.

Challenge to patients

I challenge patients, as the ultimate consumers, to assume greater responsibility for money spent on their behalf. We need to empower the patient to participate in the financial and medical choices of the care they receive. Rather than having a third-party payor make all of those selections, the patient should have some type of financial interest in determining what and how much care they receive. The fruit that you cultivate is always sweeter than one given to you.

Challenge to government

I challenge the state and federal governments to live up to the promises that they have made. For example, the federal government in the 1960s, and congresses and presidents since then, have created the promise to the American people that when they get old, the government will take care of their health care needs. This has proven to be a hollow promise. Every time they come up with a new service that they will not cover, every time they come up with a new punitive

Continued on next page

PRO mechanism to arbitrarily and capriciously decide what is unnecessary care, every time they come up with a system like DRGs to ratchet down payments, the government's promises ring more hollow and the state and federal governments are reneging on their promises.

At the state level, Gov Thompson should live up to promises he made to this State Medical Society a year ago to adequately fund Medical Assistance for obstetric and pediatric services. Unfortunately, the governor's recent budget proposals have not fulfilled this promise. And the Legislature and governor should live up to the broader commitment of truly providing access to care for all persons covered by Medical Assistance.

Many programs created at the federal and state level have succeeded in providing care, not because of the government that created them, but in spite of that government. To the extent that they have succeeded, it has been because of medicine's collective sense of obligation to care for those in need.

All too often, the federal and state government have relied on the medical profession's moral and ethical creed of providing care to those in need, regardless of their financial resources.

I challenge the government to live up to promises made to both physicians and the patients they serve. Is it any wonder that fewer and fewer of us trust the federal government? We cynically watch $250 billion to $500 billion applied to bailing out the savings and loan industry while being told that the federal budget must be balanced by using RBRVS in ways never intended and by delayed claims processing. Government has had an undistinguished history in recent years.

It is high time that the state and federal governments live up to promises that have been made, and stop making new promises that they cannot keep.

Cyril M. "Kim" Hetsko, MD, the 1991-1992 SMS president, challenges society to fulfill its health care obligations.

Challenge to pharmaceutical industry

I challenge the pharmaceutical industry to renew its obligation to provide innovative therapies in a cost-effective manner. I would not deny these companies reasonable returns on their investments, but in recent years the cost of pharmaceuticals has far out-paced the rate of increase for health care costs. Some firms have gone overboard in their desire for stockholder profits. I call upon the pharmaceutical industry to show self restraint and assure the public that its motives are not only the motives of greed and profit.

Challenge to industry

I challenge all businesses in the state to provide, to the best of their abilities, at least modest health insurance coverage for their employees.

At both the state and local levels, the Wisconsin business community has been taking an increasingly active role in looking at physician and hospital costs in an attempt to lower the costs they incur for their employees' health care. I challenge the business community to spend the same amount of time and energy to addressing the fundamental factors

Cyril M. "Kim" Hetsko, MD, (l) is sworn in as the 1991-1992 SMS president by Richard H. Ulmer, MD, (r) chair of the SMS Board.

that all agree are driving up health care costs. These factors include: the medical liability system; the lack of adequate government funding for Medicare and Medical Assistance, which result in the shifting of these costs to the non-government payors (or in other words, to business); and the lack of coverage for adequate primary and preventative care for some Wisconsin citizens, which results in higher costs down the line for all of us.

While I applaud the business community for its concerns, it must work on addressing these problems. Further study, further planning will only lead to more excuses. As Bo Jackson, who is coming to know medicine a lot better, says: Just do it!

Challenge to insurers

I challenge the insurance industry to accept responsibility for its critical role in the health care financing system, rather than just throwing up its hands and absolving itself by saying that cost increases are merely being passed through.

I challenge the health insurance industry to return to the basic premise of insurance, which is to widely share the risks we all face. Stated a bit differently, a large number of insureds pay into a fund to protect the unfortunate few who have claims to pay. In returning to this basic premise, this may mean, among other things, moving away from the current system of underwriting, which often denies coverage to the people who need it the most.

Challenge to hospitals

I challenge hospitals to return not only to embrace their original mission of providing care for the sick, but to do it in a way that reflects the needs of medically under-served citizens of our state. Throughout the state, there are rural and urban hospitals fighting to stay alive while fighting for the health of the people in their communities. At the same time, there are other hospitals that are seemingly more concerned with the bottom line and expanding into relatively over-served and affluent areas while neglecting areas with our neediest citizens.

We have a wonderful network of hospitals surrounding this city, but where we used to have four or five hospitals in inner-city Milwaukee, there is now only one–and the state is having to help financially rescue this institution. And, unfortunately, by all measures, the health status of this inner-city population is the poorest in the state.

I challenge hospitals to spend less time competing with each other for the affluent patients and the glamorous services, and to redirect some of that energy into taking care of the sickest and the neediest.

Challenge to medical schools

Since our state medical schools have a special responsibility in molding the future health care delivery system, I challenge them to continue to inculcate in their students the arts of compassion, caring and primary care, along with the latest high-tech science. High technology has limited intrinsic value unless it can be delivered to the patients who need it. I challenge the medical schools to revitalize the Wisconsin idea and to enable the state's physicians to deliver high-tech medical care in a cost-effective manner for the citizens of Wisconsin.

We have a good health care system in Wisconsin, but it can be better. I have outlined, tonight, how we may face the challenges of the '90s, and how all the players in the health care system must build on the inherent strengths of Wisconsin's health care system.

A final challenge

A final challenge to all of us is to quit arguing about who is kicking in the barn door. Let's build one that more effectively opens.

The time for action is now. Let us all accept our responsibilities and do our part to assure that access to quality medicine is preserved for the citizens of this great state. I thank you.❑

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Secretary's address
A profession worth fighting for

As my children grow up, I find myself spending more time teaching them about making choices. I am trying to teach them how to make good choices, choices for which they will be accountable, choices which should benefit them and not hurt others. It reminds me that in a democracy, choice is both our greatest right and our greatest responsibility.

The United States is on the verge of making choices concerning its health care system. One can hardly pick up a newspaper without finding a new proposal or coalition vowing to cure the woes, real or perceived, of the current system. Momentum is building for major change.

Examples of that momentum abound. Sen Edward Kennedy is proposing a required employer-provided basic benefits plan for all full-time employees and dependents. Representative Stark thinks the solution is national health insurance and a long-term care package. AFL-CIO President Lane Kirkland is touting a play-or-pay approach, in which employers would either provide insurance coverage or pay a tax to a government-run fund. The AMA has offered Health Access America. The insurance industry is proposing its own remedy. Business alliances across this state and the nation are pressing for reform. The proposals are many, but they all have one thing in common. The choices they force us to make are hard.

As a profession, physicians have been reluctant to talk about the choices. Perhaps it is because choice suggests change, and all too often change has been detrimental to medicine. It is understandable that with all the hassles doctors face today the notion of further change may not be met with enthusiasm. But we all know that change is inevitable, and the choices of change in health care are now being debated. Physicians are responsible for that care and must participate in those difficult deliberations.

Sometimes my 11-year-old son has a hard time deciding among his choices. If he is unable to decide even after a dose of parental guidance, my wife or I must step in and decide for him. Physicians may soon find themselves in a similar situation. If you do not weigh the options, identify the best choice for your patients and profession, and assume a leadership role in pursuit of that choice, someone else will make that choice for you. It could be the government, the insurance industry or the business community. They are all eager to offer their solutions.

Consider for a moment, some of the choices being debated. The Canadian health care system continues to be cited as a solution to US health care problems. That choice would offer care to all. It would also cost more than the current system, cause patients to wait in line and discourage technological innovation. It would be a difficult choice.

Another option under discussion is the implementation of universal health insurance–a basic benefits approach. That choice would also improve access, particularly for the 37 million Americans who now lack health insurance. It could simplify paper work and reduce the number of entities with which we now must deal. It would, however, significantly increase the costs to business and government and, ultimately, to the consumer and taxpayer. Another hard choice.

Others suggest the rationing of care as a viable choice. All eyes are on Oregon as that state grapples with the hard choices of prioritizing medical care for Medicaid recipients. Who among us is worthy of playing God, of deciding which treatments and medicines will be dispensed and who will and will not receive them. Onerous choices indeed.

Thomas L. Adams, CAE

Continuation of the current system with marginal adjustments and fine tuning is also a possibility. That option, we know, will continue the disparity in access to care and further compound the complexity of the system but could salvage the benefits of the present system. More hard choices.

We cannot, however, sit out the debate. We must talk about the choices with one another, with legislators and bureaucrats, with insurance companies and business groups, and with your patients. Physician guidance in general, and your leadership in particular, is required. As active participants in organized medicine, as delegates to this body, you must impress upon your colleagues the necessity of

Continued on next page

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involvement in the debate. Who knows better the successes and failures of the current system, the needs of patients and the value of health care? Revising the current system or devising a new one without physicians' active participation would be detrimental to all.

Your medical society is working hard to represent you on the numerous fronts of the debate. The SMS has recently negotiated a series of system reforms–with the Wisconsin Manufacturers and Commerce, the Wisconsin Hospital Association, the health insurers coalition, and others--that range from full Medicaid funding to public participation in hospital capital expansion projects. This proactive stance by the Society is a first step to ensuring that the profession will be at the table for Wisconsin's version of the national debate.

These first steps taken here in Wisconsin demonstrate that you and your fellow physicians still have the opportunity to shape the future of medicine rather than have it imposed on you.

Two things are certain: health care *will* be a major issue in upcoming elections, and changes in the way this nation receives and pays for its health care *will* be coming. One of the changes that is sure to come is increased accountability of the profession for the quality of health care it provides. The chorus of voices calling for quality assurance has risen from every corner of America, and it has not excluded health care. This is good as far as it goes, but it must go farther. The next step must be to define what we mean by quality and to determine how we may best measure it. If this step never comes, the talk is all just hot air. If the step is in another direction, it will be over the edge and into an inescapable pit of bureaucratic quicksand.

I believe that Wisconsin's physicians are, in their daily practices, already meeting the highest standards of health care quality. Frankly, concerns of quality are not new to medicine. I can think of no profession that has been more concerned with the quality of its training, the quality of its practitioners, or the quality of its work. Nor can I think of any other profession that has had its quality so closely scrutinized, so vigorously debated, or so thoroughly regulated. Given that the level of quality in the profession can mean the difference between life and death, it is only natural that the interest in keeping that level high and climbing is strong. Physicians cannot now relinquish that responsibility, nor let it pass by default, to the government agencies, insurance companies and computer software companies now clamoring for the right to define health care quality.

The development of practice parameters is a major example of medicine's continued efforts at quality assessment and improvement. In 1980, only eight physician organizations had practice parameters; today more than 32 specialty societies have developed more than 1,100 practice parameters, and at least another 125 are in development.

Physician leadership in the creation of practice parameters, as with all health care quality improvement measures is essential. These measures must be based on valid research, sound conclusions and the true experiences of practicing physicians. Were non-physicians to design these measures, they would run the risk of basing them on misconceptions or, even worse, utopian ideals of what medicine ought to be rather than what medicine really is. Beyond merely devising and implementing quality standards lies the task of articulating those standards in ways that are meaningful to the public, to business interests and to the government. This may actually be the more important challenge.

If you will forgive the folksy analogy: let's equate the pursuit of health care quality with fishing. We know we have been landing keepers, even trophies, all along. But we have had neither scale nor ruler with which to prove it. So, we are developing our ruler–practice parameters–and we are working to make that ruler measure in inches rather than centimeters, because the public would not otherwise understand.

Once again, your Society is at the forefront of this effort. Most recently, the SMS created its own Task Force on Quality Assurance and Implementation of Practice Parameters. This task force will study and report on the issue of quality health care in general, but will focus more specifically on determining the best ways to measure quality.

In addition, the SMS has supported the state Office of Health Care Information from the time it was nothing more than a good idea. The office is charged with collecting, analyzing and reporting health care data on behalf of the people of Wisconsin. Your president, Dr Roger von Heimburg, has been a member of the office's board of directors since its inception.

Discussion alone will not be enough: physicians must get involved in the choices. You must assume a leadership role in the hard choices. Only your involvement in your local communities, at the grass roots, will ensure that the health care system will meet the needs of your patients and your profession in the future.

Yes, that nature of your daily work could be affected by the coming changes in health care. Yes, the health and strength of your profession could be affected. And yes, you may have to adjust your financial expectations. But more importantly, the health of your patients is at stake in the changes that emerge from the coming dabate. It is to their welfare that you are dedicated as professionals, so your participation–your leadership–in the health care reform debate becomes part of your professional responsibility.

The men and women in this room

are the leaders of organized medicine in this state. It is imperative that when you return to the districts that you encourage and facilitate a discussion among your peers and within your community of the choices at hand.

Leadership requires both an open mind and a measure of creativity. It is not for the faint of heart. There can be no holding on to the past at all costs, no proverbial lines drawn in the sand, no digging in of the heels and rigid refusal to entertain new ideas. AFL-CIO President Kirkland described his organization's strategy on health care as not committed to any rigid single plan. Labor, he said, is in a negotiating posture and intends to approach health care reform in a practical way. Organized medicine will do well to adopt a similar posture. It is time to open minds and consider options. For, as Winston Churchill once told the British House of Commons, "If we open a quarrel between the past and the present, we shall find that we have lost the future."

We must leave this annual meeting prepared to do whatever is necessary to combine the political, social, financial and intellectual powers of Wisconsin's physicians for the good of medicine's future. You must believe in American medicine without being convinced that medicine alone has all the right answers. You must believe in organized medicine without being convinced that it can accomplish miracles–or that it can do the job with you or without you. We will suffer losses, we will make compromises, and we will face frustrations, but if physicians remain united, active and alert, we will emerge from this crucible stronger than when we entered it.

The power of medicine rises from something more essential, more profound than mere politics or economics. What the reformers have forgotten or, perhaps, never perceived is that despite all the criticism, litigation, pragmatism and regulation, the act of healing is still, at its core, an act of love. And in that fact lies a strength and stamina that surpasses all understanding.

Deeper than buyer and seller, provider and consumer, or physician and patient, medicine is a human-to-human interaction that requires and inspires that which is most noble in us. I know of no other profession, no other group of people, whose day-to-day work elicits such passion. I do not say this in feigned adulation or abstract admiration. I say it as a reminder: Whatever obstructions we may encounter, whatever slanders we must endure, we must not forget that medicine remains one of the most stimulating, rewarding and honorable of all professions.

If we shun the debate we will lose the opportunity to affect the future. Your future. The future of medicine. The future of your patients. We cannot relinquish that professional responsibility. Your profession is worth fighting for, and your Society is proud to bear your banner.

Thank you.❑

Awards presented at the SMS annual meeting

EACH YEAR, during its annual meeting, the SMS recognizes leaders in health care, both physicians and non-physicians, who have made significant contributions to the health and well-being of Wisconsin citizens. The following awards were presented during the 1991 annual meeting in Milwaukee.

Fifty Year Club

Each year, the SMS honors its members who have served the profession and patients for more than 50 years. This year, 56 physicians were inducted into the 50 Year Club during the Board of Directors dinner at the annual meeting. Graduates of the class of 1941 include:

- Donald S. Ackerman, MD, Scottsdale, Ariz
- Paul Bassewitz, MD, Sheboygan
- Harold A. Bjork, MD, Kenosha
- Robert F. Boock, MD, Beaver Dam
- Frank J. Brown, MD, Eau Claire
- Simon Cherkasky, MD, Kaukauna
- William L. Coffey, Jr, MD, Wauwatosa
- Eugene G. Collins, MD, Elm Grove
- Paul M. Cunningham, MD, Appleton
- Paul C. Dietz, MD, La Crosse
- Carl A. Ender, MD, De Soto
- Louis E. Fazen, Jr, MD, Fort Pierce, Fla
- Patrick J. Finucane, MD, Eau Claire
- Milton S. Freedman, MD, Milwaukee
- Leland E. Friedrich, MD, Brownsville
- Richard P. Fruehauf, MD, Superior
- Rocco S. Galgano, MD, Delavan
- Farrell F. Golden, MD, Madison
- Frank J. Gouze, MD, Sun City, Ariz
- Louis D. Graber, MD, Oshkosh
- Maurice Greenberg, MD, Dousman
- Vernon G. Guenther, MD, Oshkosh
- Douglas A. Gutheil, MD, DePere
- Erwin J. Jelenchick, MD, Milwaukee
- Marvin S. Kagen, MD, Appleton
- Robert Karen, MD, Milwaukee
- Donald Kindschi, MD, Prairie du Sac
- Jack A. Klieger, MD, Milwaukee
- William R. Kreul, MD, Racine
- Gregory P. Langenfeld, MD, Theresa
- Francis P. Larme, MD, New Holstein
- Robert H. Lehner, Sr, MD, Racine
- Russell F. Lewis, MD, Madison
- James F. Maser, MD, Rice Lake
- James F. McDermott, MD, Wauwatosa
- Kilian H. Meyer, MD, Richland Center
- James L. Murphy, MD, Park Falls
- John R. Nebel, MD, Neenah
- John R. Nickelsen, MD, Racine
- Philip B. O'Neill, MD, Milwaukee
- Ben M. Peckham, MD, Middleton
- Edward L. Perry, MD, La Crosse
- Emery M. Randall, MD, Boscobel
- Robert C. Randolph, MD, Manitowoc
- Donald M. Ruch, MD, Hubertus
- Paul W. Ryan, MD, Mountain Home, Ariz
- Charles E. Schmidt, MD, Delray Beach, Fla
- Myron Schuster, MD, Racine
- Gene W. Sengpiel, MD, Woodruff
- Lionel T. Servis, MD, Venice, Fla
- Richard C. Shannon, MD, Wausau
- Morris Siegel, MD, San Diego, Calif
- Philip H. Soucheray, MD, Bayfield
- Joel E. Taxman, MD, Milwaukee
- Raymond G. Welsch, MD, Kenosha
- William P. Young, MD, Madison

Houghton Award

The Houghton Award of the SMS Charitable, Educational and Scientific Foundation is presented each year to senior medical school students who demonstrate scholastic excellence, extracurricular acheivement and interest in medical organization. Recipients received a check for $500 and an engraved plaque which were presented at the 1991 annual meeting.

Recipients of the 1991 Houghton Award are D. John Bennett, a senior at the Medical College of Wisconsin (MCW) and Jonathan Berkoff, a senior at the University of Wisconsin-Madison.

Bennett, from Milwaukee, was recommended for the award by Herbert M. Swick, MD, MCW associate dean for academic affairs, who said "the faculty have commended John for his thorough and conscientious approach to patient care as well as his effectiveness working as a member of a medical team."

Bennett is president of the MCW Applicant Host Program, and was elected to Alpha Omega Alpha Medical Honor Society. He was also a recipient of the first Stavri and Olga Joseph Scholarship for leadership and academic excellence.

Berkoff, from Milwaukee, was recommended to receive the award by Arnold L. Brown, MD, dean of the University of Wisconsin Medical School.

"Committed to the care of others, Jonathan has combined a solid academic background with significant contributions to the medical school community," said Brown.

Berkoff is a member of the SMS, and has served on its Board of Directors as a medical student representative, as well as the AMA, Dane County Medical Society, and Hastings Center for Medical Ethics. He is also a past president of the Medical Student Section of the AMA and SMS.

Beaumont Lecture Award

Established by the SMS in 1957, the

William Beaumont Memorial Lecture commemorates one of Wisconsin's pioneer surgeons. Sponsored by the SMS Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society, distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. The lecture is given each year during the surgery meeting of the SMS annual meeting to honor William Beaumont, an army surgeon, who in the 1830s performed a series of experiments on digestion that laid the foundation for understanding the phenomenon.

This year's award was presented to Alexander Walt, MD, of Detroit, who spoke on "A Surgeon for All Seasons."

Elvehjem Memorial Lecture

The Elvehjem Memorial Lecture was established in 1962 to honor the memory of Conrad A. Elvehjem, PhD, the 13th president of the University of Wisconsin and an internationally recognized authority on biochemistry. Sponsored by the SMS Charitable, Educational and Scientific Foundation, the award is designed to perpetuate Dr Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians.

The 1991 award was received by Charles Junkerman, MD, of the Medical College of Milwaukee, who gave a lecture on "What Has Happened to the Doctor-Patient?"

Meritorious Service Awards

Ten physicians who concluded terms of office on the Board of Directors and the SMS committees and commissions, received the Meritorious Service Award for exceptional leadership and dedication to the State Medical Society of Wisconsin and the health of Wisconsin's citizens. They are:

- Albert H. Adams, MD, of Milwaukee, for his 11 years of service as a member of the Commission on Mediation and Peer Review, having served as chair for the past year.
- Conrad L. Andringa, MD, of Madison, for his 9 years of service as a member of the Committee on School Health, having served as chair for the past 3 years.
- Vernon N. Dodson, MD, of Madison, for his 11 years of service as a member and past chair of the Committee on Environmental and Occupational Health.
- Charles S. Geiger, MD, of West Bend, for his 9 years of service as a member and past chair of the Commission on Mediation and Peer Review.
- Kenneth I. Gold, MD, of Beloit, for his 9 years of service as a member on the Commission on Continuing Medical Education, having served as chair for the past 3 years.
- George W. Kindschi, MD, of Monroe, for his 9 years of service as a member of the *Wisconsin Medical Journal* editorial board.
- Roland R. Liebenow, MD, of Lake Mills, for his 9 years of service as a member and past chair of the Committee on Aging, Extended Care Facilities and Home Health Care.
- Larry A. Lindesmith, MD, of La Crosse, for his 11 years of service as a member of the Committee on Environmental and Occupational Health, having served as chair for the past two years.
- James J. Tydrich, MD, of Richland Center, for his 10 years of service as a member of the State Medical Society Board of Directors representing District 2.
- John B. Weeth, MD, of La Crosse, for his 9 years of service as a member of the Committee on Medicine, Religion and Ethics, having served as chair for the past 2 years.

The 1991 Fifty Year Club. See page 416 for the complete membership list.

Continued on next page

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Service Recognition Award

This year, seven physicians who retired from service on a SMS commission or committee received the Service Recognition Award for dedicated service to the SMS, the profession of medicine, and the people of Wisconsin. They are:

- Domenick S. Bruno, MD, of Milwaukee, for 11 years of dedicated service to the Commission on Mediation and Peer Review.
- Charles W. Fishburn, MD, of New Berlin, for 10 years of dedicated service to the Committee on Environmental and Occupational Health.
- W. Warren Garitano, MD, of Marshfield, for 12 years of dedicated service to the Committee on Mental Health.
- Raymond R. Johnson, MD, of Wauwatosa, for 9 years of dedicated service to the Committee on Health Care Financing and Delivery.
- John C. Oujiri, MD, of Ashland, for 9 years of dedicated service to the Physicians Alliance Com-mission.
- Edwin L. Overholt, MD, of La Crosse, for 3 years of dedicated service to the Task Force on AIDS.
- James V. Seegers, MD, of Elkhorn, for 9 years of dedicated service to the Committee on Medicine, Religion and Ethics.

Presidential Citation

Since 1959, the SMS president, with the approval of the Board of Directors, has had the privilege of presenting a presidential citation to a physician or non- physician who has made a truly outstanding contribution to medicine or the public health.

This year, the SMS, its president, and its Board of Directors, has chosen to bestow this honor on the many Wisconsin physicians who have been called up from their practices to serve in the military during the Persian Gulf War, and to their families who have endured the hardships of their absence.

Health Leadership Award

The Health Leadership Award was created by the SMS Board of Directors to honor a person or persons in government service who have made significant contributions to the development of health care policies which benefit the people of Wisconsin. This year, state Senators Brian Rude (R-Coon Valley) and Bob Jauch (D-Poplar) received the 1991 Health Leadership Award of the State Medical Society of Wisconsin.

Senator Rude has played a key role on many important health care issues, particularly those addressing access to health care in rural areas. Rude's work on medical liability reform and medical education are prime examples of his contributions to health care policy development.

Rude was elected to the Senate in 1984 after being elected to the Assembly in 1982. He is currently the assistant minority leader.

Senator Jauch has been sensitive to the health care needs of rural Wisconsin and has been an outspoken legislator who has fought for continued access to health care.

He has been a leader in efforts to reduce the critical shortage of physicians in rural Wisconsin, and to take other steps necessary to build a sound rural health care system.

Jauch is serving his second term in the state Senate, having previously served two terms in the state Assembly, and is currently a member of the Joint Finance Committee, and the Senate Committee on Agriculture, Corrections, and Human Services.

The Director's Award

The Director's Award is the highest award bestowed by the SMS and is granted only on occasion to those who have served with outstanding distinction the science of medicine, physicians and the citizens of the state of Wisconsin. In the 62 years since it was established, 52 awards have been presented.

This year the award was presented to DeLore Williams, MD, of Elm Grove. DeLore Williams, exemplified the physician devoted to the public good. Whether it was helping a patient, or assisting his profession to respond collectively to the demands of society, Dr Williams continued to protect and nurture his patients while working toward a successful State Medical Society.

Born in Ogden, Utah, Dr Williams moved to Wisconsin to attend the former Marquette University School of Medicine (now the Medical College of Wisconsin). After completing an internship at Columbia Hospital in Milwaukee, Dr Williams completed his residency training at the Veterans Administration Hospital in Milwaukee. Prior to completing his residency, Dr Williams served in the US Air Force. As an internist, Dr Williams was dedicated to his patients and practiced in West Allis for many years.

A man of deep integrity and infinite wisdom, Dr Williams has been a leader and key figure at several levels within organized medicine. He has served the SMS in a variety of capacities including the Board of Directors, its Finance Committee and the former Commission on Public Policy. Dr Williams also served as a delegate to the AMA from 1977 to 1990. A member of the Medical Society of Milwaukee County, Dr Williams was also chair of its Legislative Policy Committee for 4 years.

A long background of dedicated and active involvement in both state and legislative affairs in Wisconsin has made Dr Williams a respected member of the profession. He has served on the WISPAC Board of Directors since 1985, and is a sustaining member of WISPAC/ AMPAC. Dr Williams is a member of the Physicians Alliance Commission,

and was chair of the Physicians Alliance Committee of Milwaukee County.

Dr Williams has earned the respect and admiration of many of his colleagues in Wisconsin and the leadership of the AMA. Darold F. Treffert, MD, former SMS president has said that, "Dr Williams is held in the highest regard by the leadership of the State Medical Society of Wisconsin, the medical community in Milwaukee, and a large number of physicians around the state who have come to identify him with determined, thoughtful, and provocative presentations of legislative issues."

Dr Williams has a distinguished medical career as well. He has served on the Board of Directors of the West Allis Memorial Hospital, and as a member of the Finance Committee, Long Range Planning Committee, Public Relations Committee and Quality Care Committee.

Involved in community affairs, Dr Williams has served as a member of the West Allis Chamber of Commerce Board of Directors and was its president in 1963. He also has served as a member of the Board of Directors of Central Bank of West Allis, Southeastern Wisconsin Health Systems Agency, and as a representative of Medical Society of Milwaukee County Jobs Bill Task Force in the formation of ShareCare (now WisconCare), a program of health care for the temporarily unemployed.

Julie Sneider (l), of the "Business Journal," receives the first SMS Medical Issues Reporting Award from SMS President Cyril M. "Kim" Hetsko, MD (r).

Distinguished Service Award
Established in 1974, the Distinguished Service Award is presented each year to a Wisconsin physician who has made outstanding contributions in the field of medical education.

This year's recipient, Thomas C. Meyer, MD, of Madison, received his medical degree from Witwatersrand University in 1950. He completed his internship in Johannesburg, South Africa, and Edinburgh, Scotland. In 1954, Dr Meyer moved to North America to complete residencies in cardiology and neurology at Johns Hopkins Hospital and the University of Saskatchewan in Canada.

In 1961, Dr Meyer was appointed assistant professor of pediatrics at the University of Wisconsin and, in 1965, was appointed assistant dean of the University of Wisconsin Medical School and chairman of Continuing Medical Education. Dr Meyer was appointed associate dean and chair of Continuing Medical Education in 1967 and in 1970, professor of pediatrics and continuing medical education.

Dr Meyer is active in many professional associations including the Association for Hospital Medical Education, American Board of Pediatrics, the SMS and the AMA. Dr Meyer's university affiliations included chair of the continuing medical education committee, member of the University Hospitals board, chair of the Educational Improvement Grant Committee, and a member of the Educational Policy Council.

Medical Issues Reporting Award
Established in 1990, the Medical Issues Reporting Award is presented to a Wisconsin journalist who best reports on medical issues during the preceding calendar year. This year's recipient was Julie Sneider, health reporter for *The Business Journal.*

A graduate of the University of Wisconsin, Sneider has been a health care reporter for *The Business Journal* since 1989. She was employed at the *Waukesha County Freeman* from 1984 to 1989.

Continued on next page

Sneider won the Daily Reporter Award from the Center for Public Representation for civil liberties journalism in 1986, and won first place for a series in 1987 from the Wisconsin Press Women.

Reporters working for Wisconsin newspapers and magazines, and radio and television stations are eligible.

Wisconsin Medical Journal Writing Contest and the Graduate Student Nursing Writing Contest

During the past year, the *Wisconsin Medical Journal* sponsored a writing contest for medical students, residents and graduate nursing students. Intended as an annual event, this contest is meant to encourage and reward good science writing and to cultivate interest in the Society among students and residents.

This year's winner of the student writing contest was Kenneth Charles Goldberg for his paper entitled, "The potential for the elimination of measles in the modern age." The graduate student nursing writing contest winners are: Jill M. White, of Brown Deer, for her paper, "Music therapy: A means of reducing anxiety in the myocardial infarction patient," and Lori A. Wastlick, of Eau Claire, for her paper, "Family protective thinking about cardiac events: Nursing interventions to promote maintenance of family health behaviors."

Erwin R. Schmidt Interstate Teaching Award

Established in 1966, the Erwin R. Schmidt Interstate Teaching Award is given every 3 years to a physician from Wisconsin who is deserving of special recognition for medical teaching within the boundaries of the state. This year's recipient is Joseph J. Mazza, MD, of Marshfield.

The Interstate Postgraduate Medical Association of North America presents the Erwin R. Schmidt Teaching Award to a physician "who has served the profession with distinction as a practicing physician and teacher." The award is named in honor of Erwin R. Schmidt, MD, a former trustee of Interstate, who for many years was chair of the department of surgery at the University of Wisconsin Medical School.

Mazza received his medical degree from Loyola University and served his internship at Cook County Hospital, in Chicago. He completed his fellowship at the Mayo Clinic in Rochester, Minn.

Mazza is the head of the Section of Hematology, assistant director of the Internal Medicine Residency Program, and Residency Review Committee and Residency Recruiting Committee chair at the Marshfield Clinic. He is a member of the American Society of Internal Medicine, SMS, American Society of Clinical Oncology, Wood County Medical Society, American Society of Hematology, a Fellow in the American College of Physicians, currently ACP governor for the state of Wisconsin, and past president of the Wisconsin Society of Internal Medicine.

Mazza is a member of the Education Committee of the Marshfield Medical Center and was the vice chair of the SMS Commission on Continuing Medical Education in 1988.He also serves as director of CME for the Department of Medicine at the Marshfield Clinic.

Mazza has won numerous teaching awards including, the University of Wisconsin Medical Alumni Association Teaching Award in 1979, 1980, 1981 and 1990; the George Magnin Teaching Award in Internal Medicine in 1981.

Physician-Citizen of the Year Award

Since 1982, the Physician-Citizen of the Year Award is presented to a Wisconsin physician for outstanding contributions to his or her community and patients. For the first time, under the direction of the Board of Directors, this year's Physician Citizen of the Year Award is presented to a physician in each of the eight Society districts. They are:

District 1–Kevin J. Fullin, MD, of Kenosha

District 2–William E. Scheckler, MD, of Madison

District 3–Larry A. Lindesmith, MD, of La Crosse

District 4–Christopher G. Koeppl, MD, of Rhinelander

District 5–Terry L. Hankey, MD, of Waupaca

District 6–Fred H. Walbrun, MD, of Green Bay

District 7–N. Hans Rechsteiner, MD, of Spooner

District 8–Bruce D. Gordon, MD, of Hurley ❑

Thomas C. Meyer, MD, winner of the 1991 Distinguished Service Award.

Sen Brian Rude, winner of one of two 1991 Health Leadership Awards.

The history of the CES Foundation

The Charitable, Educational and Scientific Foundation was chartered by the SMS in 1955 as a private, non-profit, non-stock corporation to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The foundation's scope of interest has grown because of bequest contributions; therefore, a number of worthy programs affecting medical education and health care needs in Wisconsin can be accomplished. The future of the foundation holds an array of opportunities and challenges.

Benevolent assistance. The CES Foundation is ever sensitive to the needs of people who are the victims of adversity. Although the foundation's capacity in dollars has been limited, it has often been able to arouse the spirit of caring among physicians and the public when special needs arise. Assistance is looked at as an investment in the future and not as charity.

Education. Postgraduate teaching programs are a major thrust of the foundation. With CES Foundation support, the Medical Society's program of accreditation of continuing medical education, initiated in 1976, continues to move forward with increasing success. This effort has greatly expanded the availability of quality postgraduate learning opportunities for Wisconsin physicians and allied health personnel.

Funding from the foundation's Barbara Scott Maroney Memorial Fund for Research on Diabetes support special research projects, summer camp scholarships for diabetic children, publication of scientific articles or presentation of scientific speakers on the subject.

The foundation makes grants available to organizations striving to stimulate student interest in science and expose them to wide varieties of science related careers. Annually, the CES Foundation recognizes outstanding achievements in student science research by high school and middle school students in Wisconsin through contributions for awards to the Wisconsin Science Congress and the Wisconsin Science Olympiad.

As a project of the state auxiliaries, the Workshop on Health, a health education program for high school students, has featured such topics as anorexia nervosa, eating disorders, sexually transmitted diseases, teen suicide, alcohol and drug abuse, and wellness.

Student loans, grants and scholarships. One of the most important activities of the CES Foundation is the student loan program. Established in 1955, the foundation's general student loan fund is designed to assist needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. Long-term, low-interest loans are interest-free until after the student graduates. Personnel in the financial aid departments of Wisconsin medical schools cooperate with the foundation in identifying needy and deserving students.

Many young men and women can achieve their medical careers only because of the availability of large, low-interest loans. In fact, the average medical student today can anticipate graduating with debt obligations ranging from $50,000 to $75,000. In 1990, the foundation granted 46 loans to medical and allied health students for a total of $104,500. Repayments in 1990 total $79,533.20. Since the loan fund was established, 1063 students have received $1,510,574 in long-term, low-interest loans.

Although the foundation's primary emphasis is in loans, some outright scholarships and grants are made to fulfill the wishes of some donors and the needs of certain potential recipients. These special health career student loan and scholarship funds are administered by the foundation according to the wishes of the individual or organization establishing and supporting the fund.

Continued on next page

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For example, a county medical society auxiliary may make an original endowment to the CES Foundation to establish a student loan or scholarship fund in the county auxiliary's name. The county auxiliary, as the benefactor, may work with the foundation to determine what restrictions, if any, are to be placed on the loans. Such restrictions may include residency requirements, career specifications, educational facility, limitation on year of study, and dollar amounts.

Applications may be obtained from the CES Foundation, 330 E Lakeside St, Madison, WI, 53715; or the medical college's financial aid offices. The CES Foundation furnishes an annual accounting to the benefactor or sponsoring organization.

To inquire about how you or your organization can establish a special student loan or scholarship fund, contact Julie A. Hein, 330 E Lakeside St, PO Box 1109, Madison, WI 53701; or phone 608-257-6781 (Madison area) or toll-free in Wisconsin 1-800-362-9080.❑

Facts about the CES Foundation

The SMS Charitable, Educational and Scientific Foundation is a non-profit, non-stock Wisconsin corporation, chartered in June 1955. As stated in the by-laws, the foundation's purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind."

Management
The foundation's governing power is vested in a board of trustees composed of directors and officers of the SMS, other medical and non-medical members elected by the board of directors and one representative elected by each component medical society. Non-medical members may be elected from time to time by the SMS Board of Directors, but the number of such trustees shall not at any time be less than five or more than ten.

The board of directors of the corporate trustees consists of 18 members including the president, vice president and treasurer of CESF, and in addition, 12 members, seven of whom may be non-medical trustees, each elected for staggered 3-year terms.

Registration
The foundation is registered with the secretary of state as a charitable organization for purposes of contributions and fund-raising under §440.41(2) of the Wisconsin Statutes.

Legal
The foundation retains Robert B.L. Murphy of the firm Murphy & Desmond, SC, 2 E Mifflin St, Madison, WI 53703; 608-257-7181, for advice on legal and tax matters. Julie Ann Hein serves as the managing director, works directly with the secretary and deputy secretary of SMS, and is responsible for all duties of the foundation.

Tax information
Contributions to the CES Foundation are tax deductible under both state and federal tax laws. The foundation is a 501(c)(3) non-profit corporation. As in all matters relating to your financial affairs, the valuation, form and tax aspects of gifts, to the foundation should be discussed with your attorney, accountant or other advisor.

Officers
President: Gerald C. Kempthorne, MD, Spring Green
Vice president: Stephen B. Webster, MD, LaCrosse
Treasurer: Richard W. Edwards, MD, Richland Center
Secretary: Thomas L. Adams,* Madison
Finance Committee chair: Richard W. Edwards, MD, Richland Center
Assistant treasurer: John K. Scott, MD, Madison

Directors
Mayor James Bittner, Prairie du Chien
Robert T. Cooney, MD, Portage
Julie A. Hein,* Madison
Cyril "Kim" Hetsko, MD,* Madison
Pauline M. Jackson, MD, La Crosse
Sandra Kontra,* Racine
Russell F. Lewis, MD, Madison
William J. Listwan, MD, * West Bend
Robert B. L. Murphy, Madison
Earl R. Thayer, Madison
Kenneth M. Viste Jr, MD, Oshkosh

**ex-officio*

Staff
Managing director: Julie A. Hein
Administrative assistant: Jane Anderson ❑

A CESF guide to gifts

GIFTS TO THE FOUNDATION may take a number of forms: cash, bequests, trusts, life insurance, real estate, stock or other securities–some physicians are making the foundation a beneficiary of their wills. Such gifts may be designated as unrestricted or for specific immediate use at the discretion of the foundation trustees. They may also be restricted or earmarked for specific purposes of interest to the donor. Likewise, these gifts may also be designated for permanent investment with only the income used to support foundation programs.

The foundation currently asks for a voluntary donation of $50 from the SMS membership through the membership dues statement and other direct mail solicitations.

Contributions provide financial aid to Wisconsin students of medicine and allied health professions, sponsors postgraduate teaching programs, stimulates research into areas of medicine and public health and promotes the preservation of medical history.

Cash gifts

Most gifts received by the foundation are in the form of cash, personal checks made payable to the CES Foundation. These gifts, as well as others, may be designated in honor of a relative, friend, or associate.

The foundation maintains a memorial program which gives the donor an opportunity to remember someone through a gift to the foundation–a living memorial. A memorial card is sent to the family with the name of the deceased and the name of the donor. The amount of the gift is not indicated. The donor will receive a card thanking them for their donation.

Bequests

A bequest is the giving of property by will. The will is designed to assure that upon death the property is distributed exactly in accord with the donor's wishes. One of the purposes of a will can be to perpetuate the donor's name or that of a friend through an organization such as the CES Foundation.

A codicil is an amendment or revision of a previously executed will. An attorney can draft it with minimal cost should donors wish to add a bequest to the CES Foundation to their will.

Gifts of life insurance

Life insurance offers an easy means to make a substantial gift as well as to provide tax advantages for the donor. A policy can be assigned to the foundation whether it is paid up, partially paid up, or new. Proceeds from such policies may be exempt from estate taxes and if the assignment is irrevocable, present values and future premium payments may qualify as charitable contributions for income tax purposes.

The gift of life insurance is deductible, usually at its cash surrender value, at the time of transfer to the foundation. Arrangements may also be made to provide life income for a beneficiary by having the proceeds placed in a gift income plan with the proceeds placed in a gift income plan with the proceeds, following the life of the beneficiary, to go to the foundation.

This plan also gives donors the satisfaction of making contributions and being recognized for it during their lifetimes.

Real estate

Any standard form of warranty deed or acceptable quit claim deed may be used to deliver real estate to the foundation.

Stock or other securities

Current gifts may take the form of stock or other securities which have appreciated in value. Gift of appreciated securities permit the donor to realize substantial tax advantages.

Personal property

Some donors prefer to make gifts of art, jewelry, antiques, rare books, furniture, or collectibles of other types such as stamps and coins. For tax purposes, the donor must determine the value of a personal property gift on the date of its transfer to the foundation.

Trusts

Some find it advantageous to make a contribution to the foundation, but retain the income from the contribution for the duration of their life or the lives of others. There are important tax advantages to these arrangements. The trustee of such "living trusts" may be a bank, trust company or the foundation.

Among the several types of living trusts are: annuity gifts, pooled income gifts, unitrust gifts, deferred payment gift annuities, and revocable life income plans.

The CESF is pleased to announce the establishment of a pooled life income fund. This planned giving opportunity permits the donor to combine the advantage of bequests and lifetime gifts in one package. The gift is commingled with other similar gifts which are held in a fund, hence the name "pooled."

Participants or their beneficiaries will receive interest income throughout their lives. Upon the death of the investor's last beneficiary, the CESF will receive the principal to reinvest or use for whatever purposes.

If you are interested in the living trust program, you are urged to contact your legal adviser, accountant, or Julie A. Hein in the CESF office at 608-257-6781 or 1-800-362-9080.❑

The Fort Crawford Medical Museum

The Fort Crawford Medical Museum is unique among educational and cultural institutions in the Midwest and the nation. Far more than a museum, it stands as a tribute to Wisconsin's physicians who have dedicated their lives to ensuring the health of the state's citizens. The museum is also a singular tool for educating the public about the prevention and treatment of injury and disease, the nature of medical care, the value of the physician-patient relationship, and the importance of keeping one's health.

The Fort Crawford military hospital, which has been designated a national landmark, and the related museum are located in Prairie du Chien near the Mississippi River. On this site in the 1830s, Dr William Beaumont carried out his famous experiments on the physiology of digestion.

The actual planning for the museum began in the 1930s when the SMS placed a granite memorial near the crumbling remains of the second Fort Crawford, which had been abandoned in 1872. In the mid 1940s, the SMS House of Delegates endorsed furnishing the hospital building as a museum. The property was deeded to the SMS Charitable, Educational and Scientific Foundation in the 1950s, and the SMS approved the completion of the museum complex, known officially as the Museum of Medical Progress. In 1964 the Stovall Hall of Health was added, which provided additional exhibit space.

In 1980, the Fort Crawford Medical Museum Endowment Fund was established to provide financial support for the museum. Over the years more than 200,000 visitors have toured the museum, yet it continues to face financial hardship and is in need of frequent repair.

The first 500 persons who contribute $1,000 or more to the Fort Crawford Medical Museum Endowment Fund will join a select group known as the Beaumont 500 and will receive a specially designed Beaumont medallion. Currently, there are 61 members of the Beaumont 500 club with 22 established pledges.

The SMS Auxiliary and county auxiliarys have taken on the Beaumont 500 Club as a challenge project. Each county auxiliary is asked to pledge $1,000 toward the club over a specified time, probably 4 to 5 years, and challenge their county medical society to provide matching funds. Many of the auxiliaries and county medical societies have accepted this challenge.

During 1990, active promotion of the museum resulted in a growth in attendance and greater visibility for the site. The 1990 Civil War encampment weekend held in July also proved to be a success and attracted museum visitors from throughout the Midwest.

The museum gift shop and the County Medical Society Auxiliaries are helping to promote and sell limited edition prints and notecards of the mural "Dr. Beaumont's Waiting Room," which graces one wall of the Society's remodeled meeting rooms.

For more information about the Fort Crawford Medical Museum, please contact Julie A. Hein at the CES foundation at 1-800-362-9080 or 608-257-6781.

Beaumont 500 members

1980
Pierce-St Croix County Medical Society

1981
Mr and Mrs Robert B. Murphy
Guy W. Carlson, MD
W. Bruce Fye, MD
Pauline M. Jackson, MD
Dr and Mrs William D. Janssen
Dr and Mrs T. A. Leonard
E. J. Nordby, MD
Karver L. Puestow, MD
John D. Riesch, MD

1982
anonymous
Marion Crownhart
E. M. Dessloch, MD
Melvin F. Huth, MD
Michael F. Ries, MD
E. A. Steffen, MD
Kenneth M. Viste, Jr, MD

1983
W. Bradford Martin, MD
Earl R. and Alice Thayer

1984
Dr and Mrs K. Alan Stormo
Dr and Mrs Chesley Erwin
Dr and Mrs Leonard B. Torkelson
Leland C. Pomanville, MD
Mrs W. D. Hoard
Dr and Mrs Ralph Hudson

1985
Dr and Mrs Roger von Heimburg
Dr and Mrs Bertram H. Dessel
Mace Garrison Zinggeler
Dr and Mrs Benjamin Brunkow
Robert T. Cooney, MD
Staff of the State Medical Society of Wisconsin

1986
Dr and Mrs William Listwan
Richard W. Edwards, MD
Amy Hunter-Wilson, MD
Kari, Doran and Kenneth Viste
Roy Selby, MD

1987
Sandra Osborn, MD
Timothy T. Flaherty, MD
Washington County Medical Society
Dr and Mrs Roland R. Liebenow
Racine County Medical Auxiliary
State Medical Society of Wisconsin

1988
Jefferson County Medical Society
Milwaukee County Medical Auxiliary
Milwaukee County Medical Society
Dr and Mrs Victor Wong

Physicians Insurance Company of Wisconsin
Dr and Mrs Ken Smigielski
Kenneth M. Viste, Jr, MD, in honor of the SMS staff
Joan Flaherty
Edward A. Burg, Jr, MD, family
SMS Services, Inc
1989
Dr and Mrs Stephen Webster
Dr and Mrs Kermit Newcomer
Sauk County Medical Society
Wood County Medical Society
Dr and Mrs John D. Wegenke
La Crosse County Medical Society Auxiliary
1990
Green County Medical Society
Winnebago County Medical Society
Auxiliary
Dr and Mrs Louis Hacker

Beaumont 500 pledges
Brown County Medical Society Auxiliary
Columbia-Marquette-Adams County Medical Society
Dodge County Medical Society Auxiliary
Eau Claire-Dunn-Pepin Medical Society Auxiliary
Fond du Lac County Medical Society Auxiliary
Green Lake-Waushara County Medical Society
Kenosha County Medical Society
La Crosse County Medical Society
Manitowoc County Medical Society Auxilary
Oconto County Medical Society
Sheboygan County Medical Society Auxiliary
State Medical Society Auxiliary
Trempealeau-Jackson-Buffalo County Medical Society
Vernon County Medical Society
Waukesha County Medical Society Auxiliary
Winnebago County Medical Society
Thomas and Diane Adams
Dr and Mrs Robert Baldwin
Dr and Mrs J D Kabler
Dr Gerald Kempthorne in memorium of father Guy Kempthorne
Dr and Mrs David and Mary Weber
Dr and Mrs Raymond C. Zastrow ❑

Foundation grant allocations

THANKS TO THE EFFORTS of a tremendous number of physicians, who have been entrusted with the responsibility of sharing the cost of providing financial contributions, the foundation is supporting a greater number of programs on a broader spectrum.

The list of grants provided by the foundation during this past year spells substantial achievement. Through physician support and leadership, the foundation hopes to encourage similar support from others. With education as its vanguard, the CESF prides itself in supporting medical education programs.

A special project of the CESF has been coordinated in conjunction with the American Hospital Association and the Center of the Study of Bioethics. An educational case-based videotape has been developed to increase physician awareness and communication between the physician and patient.

The CESF also helped to sponsor a conference in health care rationing conducted by the Health Management Alumni Association a the University of Wisconsin-Madison.

The CESF was also involved in sponsoring a training session held in the fall of 1990 which was conducted by the Wisconsin Association of Prenatal Care. As an outreach program for clinics and insurance companies, the session focused on preconceptional preparation and planning for pregnancy.

Each year at the SMS annual meeting, the CESF presents two Houghton scholarships for the outstanding senior at the University of Wisconsin Medical School and the Medical College of Wisconsin. The foundation also supports the *Wisconsin Medical Journal* by granting an award to one of the recipients of the medical writing contest.

The foundation has continued to give grants toward the sciences. Support was given toward the 1990 Wisconsin Science Olympiad and Wisconsin Science Congress.

The Wisconsin Safety Patrols, Inc rewards the efforts of outstanding safety patrol members by sending them to our nation's capitol. The foundation sponsored a delegate to this 5-day tour.

For further information regarding the CES Foundation, please contact Julie A. Hein, CES Foundation, PO Box 1109, Madison, WI 53701; 608-257-6781 or 1-800-362-9080.❑

Health Access America

The AMA proposal to improve access to affordable, quality health care.

"I can't afford to go to the doctor."

We hear that a lot from our patients these days. For the 33 million people who have no health insurance, it's a particularly acute problem.

That's why the AMA has launched a proposal to improve access to affordable, quality health care. It's called *Health Access America*. The message is being sent to Congress, the media, labor and management organizations, concerned groups like AARP, and your fellow physicians.

Simply, *Health Access America* proposes health insurance coverage for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America's physicians are leading the way to reforming the health care system by speaking out on these critical issues.

To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association

on behalf of member physicians and their patients.

Medical student writing contest winner

The potential for the elimination of measles in the modern age

Kenneth C. Goldberg, Shorewood

MEASLES, BOTH THE VACCINE and the virus, has tied its fate to humanity. Until recently the disease was so ubiquitous among *Homo sapiens* that every member of the species ever born can be assumed to have contracted it. With nearly 100% penetrance, the genetic information coded in the measles virus (family *Paramyxoviridae*, genus *Morbilli* or *Rubeola*) should be considered a transient part of the normal human genome. Along with rash and fever, measles virus is associated with bronchopneumonia, otitis media, encephalomyelitis, giant cell pneumonia, and subacute sclerosing panencephalitis.[1] Only during the last three decades has humanity evolved a technology with sufficient potency to divorce itself from this intracellular parasite.

Kenneth C. Goldberg is a second year medical student at the Medical College of Wisconsin. This paper was the winning entry in the *Wisconsin Medical Journal*'s 1990 Medical Student Writing Contest. Address reprints to: Kenneth C. Goldberg, 3909 N Murray Ave, Shorewood, WI 53211. Copyright 1991 by the State Medical Society of Wisconsin.

Following the success of the war against small pox (family *Poxviridae*, species *Orthopoxvirus variola*), launched originally in 1776 by Jennings from England and declared over by the World Health Organization in 1977 (the last case reported in the United States was in 1943), the health community looked for a new infectious disease to challenge. Measles was the natural choice. It shares the key features that made elimination of the variola virus possible: a single, stable antigenicity, and the lack of a reservoir outside of humans. The live, attenuated viruses developed by Edmonston in 1963 and by Moraten in 1968 can provide life-long immunity after one vaccination.

Driven by the alarming incidence, morbidity,[1-3] and mortality[2,4] of measles and encouraged by its new

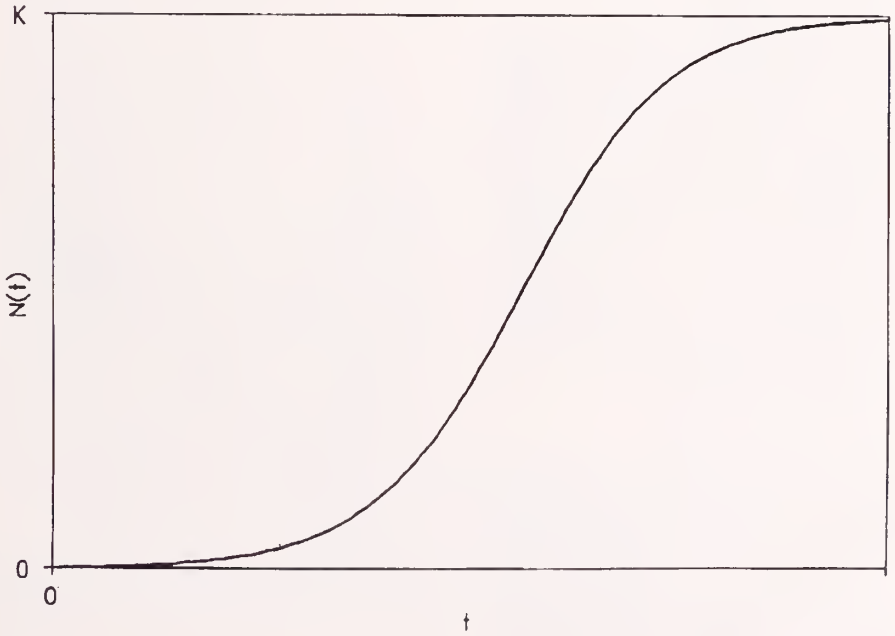

Fig 1.– Logistic growth.

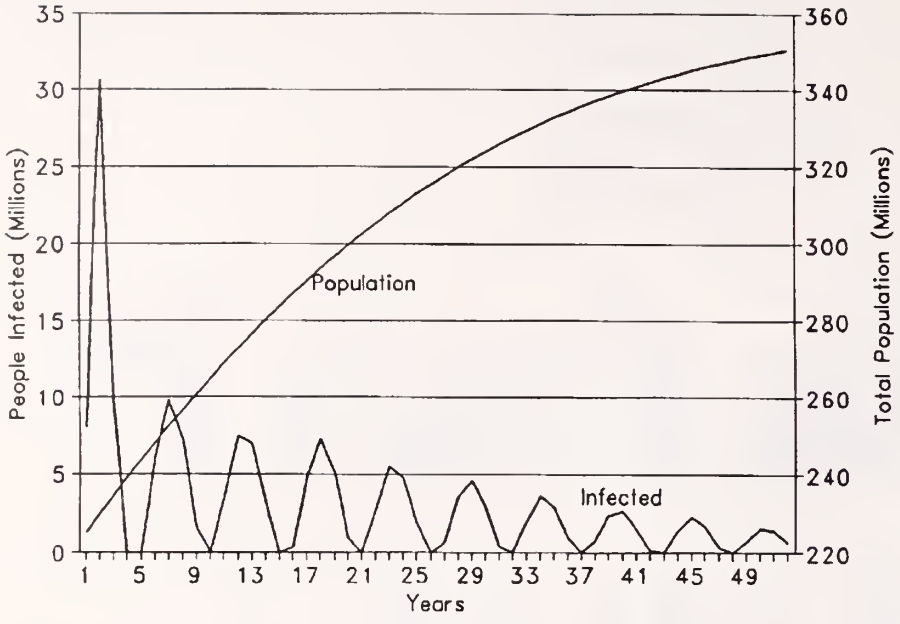

Fig 2. – Measles before the vaccine.

immunological tools, the US government set out in the 1960s to eliminate rubeola from its native population. Mass vaccination campaigns and laws designed to force compliance led to a 90% decrease in incidence from pre-vaccine levels by 1968 and to a 99% decrease in reported measles incidence by 1978.[2] The enforced extinction of measles seemed imminent.

The measles rate, however, stabilized through the early 1980s, and it has recently marked a sharp increase as we enter the 1990s. Empirical examination of the nature of measles outbreaks in the vaccine era and models of measles-human interactions cast doubt not only upon the possibility of world-wide elimination of the virus, but also on the prospect of eradicating measles from the US population.

Measles and models

The most basic features of measles infection in humans can serve as the basis of a host-parasite model. Similar models have successfully described a variety of biological situations, from rabbit and wolf populations in British Columbia to erroneous placement of depth-charges and the squid population during the Second World War.[5] The dynamics of infectious diseases and of measles in particular have been thoroughly explored by Anderson and May[6,7] and others.[8,9] This paper does not attempt to further elaborate the models proposed by these authors, but rather to show that a very simple model can describe aspects of real events.

A model should be used as a descriptive tool of, and not a substitute for, a real phenomenon. In this sense, qualitative aspects of any model rather than quantitative ones should be emphasized. The models proposed in the next section focuses on only a few aspects of measles in the United States. It has no power to describe the general phenomenon of measles and only a limited ability to explore its epidemiology. In particular, it assumes a random distribution of susceptible and immune hosts and that each non-immunized host is equally likely to contract the virus. These assumptions clearly do not reflect modern measles reality. In spite of these flaws, this simple model can, with restraint, be used to describe some of the global aspects of the possible evolution of measles in a population.

Model description

The logistic equation (Fig 1) provides a qualitatively good fit to the population dynamics of many systems. At low population (N) levels, growth is slow, limited by the number

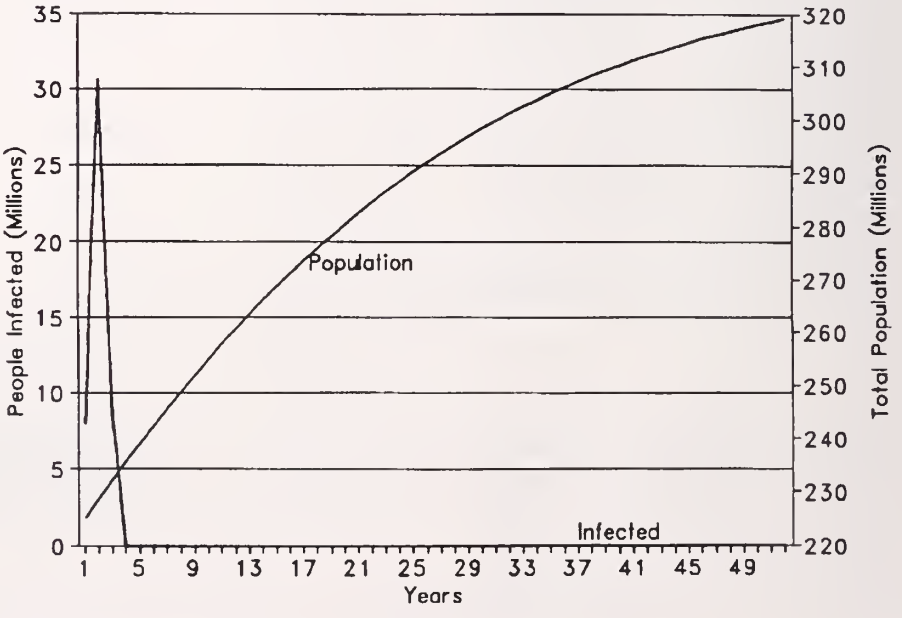

Fig 3.– The perfect measles campaign.

(1)

$$N_{t+1} = N_t e^{r*\left(1 - \frac{N_t}{K}\right)}$$

(2)

$$\text{Immigrants}(N_t) = K_{Immigrate} \times N_t$$

$$\text{VaccImm}(N_t) = K_{Percent} \times K_{Effective} \times N_t$$

$$\text{Infected}(P_t, S_t) = \text{Max}\left(S_t, S_t \times e^{K_{Attack} \times \left(1 - \frac{P_t}{S_t}\right)}\right)$$

$$\text{NextPop}(N_t) = N_t \times e^{r \times \left(1 - \frac{N_t}{K_{Sustainable}}\right)}$$

$$\text{Births}(N_t) = \text{NextPop}(N_t) - N_t$$

(3)

$$S_{t+1} = S_t + \text{Births}(N_t) + \text{Immigrants}(N_t) - I_t$$
$$I_{t+1} = \text{Infected}(P_t, S_t) + \text{VaccImm}(N_t)$$
$$N_{t+1} = \text{NextPop}(N_t) + \text{Immigrants}(N_t)$$
$$P_{t+1} = \text{Infected}(P_t, S_t)$$

of organisms that can reproduce. At higher levels, growth becomes exponential, and at levels approaching a maximum supportable population (K), growth again slows to logarithmic. The logistic equation is used in this model to describe the growth of a host (human) population toward a maximum sustainable population, and it is also used to describe the growth of a parasite (measles) toward the number of susceptible hosts. The logistic equation is parameterized by a constant representing the maximum sustainable population (K) and by a growth constant (r) related to how quickly the population (N) grows toward that maximum population. In this equation, time (t) is quantal (1).

The system of equations used to model measles in the US population consists of four difference equations that track the number of susceptible hosts (hosts capable of becoming infected), the number of hosts that will become immune either through infection of effective vaccination, the size of the total host population, and number of infected hosts. S_t represents the number of susceptible hosts at time t and is equal to the sum of the number of hosts that were previously susceptible to infection (S_{t-1}), the number of hosts born into the population, and the number of hosts that immigrated into the population less the number of hosts that became immune to the parasite during the last time period (I_{t-1}). The number of immigrants is defined as a strict percentage of the total population, and the number of newborns is determined by logistic growth of the host population (N_t) toward its maximum sustainable population ($K_{Sustainable}$) at growth rate r.

The number of hosts that become immune at time t (I_t) is equal to the number of hosts that contracted the disease and the number of hosts that develop immunity from effective vaccination. The number of infected hosts (P_t) grows in a logistic manner from the previous number of infected hosts (P_{t-1}) toward the number of susceptible hosts during the last round of replication (S_{t-1}) with growth rate K_{Attack}. Finally, the number of successfully vaccinated hosts becomes the product of the previous number of susceptible hosts (S_{t-1}), the percent of vaccine coverage, and the efficacy of the vaccine.

The model itself is defined in (2), and the utility functions it uses are presented in (3). For all subsequent simulations, t runs from 0 to 50 years, $K_{Sustainable}$=330, r=0.01, and K_{Attack}=0.3. At time t=0, S_0=25 (millions), I_0=20, N_0=225, and P_0=8. These parameters were chosen arbitrarily; measles is known to have an extremely high attack rate, hence K_{Attack}, and the initial populations reflect a crude estimate of the relative United States populations. $K_{Percent}$, $K_{Effective}$, and $K_{Immigrate}$ change from model to model.

Measles before the vaccine

Figure 2 shows the model with $K_{Percent}$ assigned zero and $K_{Immigrate}$ assigned a value of 0.5%. These and the other initial parameters roughly approximate the status of the United States in the 1950s.[2] The only way to become immune to measles under the constraints imposed on this model is to contract the disease. Notice first that the number of measles cases exhibits a periodicity of several (5 or 6) years. After an epidemic which immunizes the entire population, there are not enough susceptible

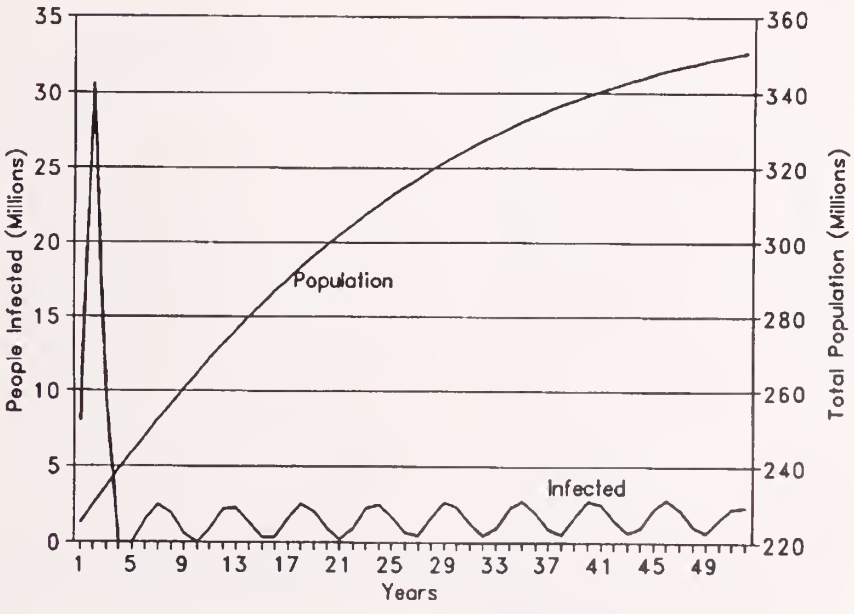

Fig 4. – The HEW scenario.

hosts to sustain the outbreaks as essentially the entire cohort becomes immune. At low infected hosts populations, parasitic reproduction is slow. After several years of the accumulation of new, susceptible births and unvaccinated immigrants, the parasite again has a large enough pool of hosts to sustain growth into the exponential portion of the logistic curve. Essentially no non-immune hosts escape the major outbreaks without infection, and appropriately measles in this simulation is exclusively a disease of the young. The initial measles peak on the graph indicates merely an adjustment of the model to the initial parameters, which were chosen arbitrarily. For this reason, the behavior of the first few iterations of the model does not hold any significance.

The amplitude of the epidemics declines over time, but this is more a reflection of the declining population growth rate than of the dynamics of parasite infection. The periodicity of the later attacks does not change. This demonstrates that the minimal threshold of susceptible hosts needed by measles to achieve exponential growth is low and will be achieved by almost any host population growth. The amplitudes decrease because the slowed population growth allows fewer new hosts to be introduced to measles during the epidemic (exponential growth) phase. This feature becomes more important when exploring the effect of immigration of parasitic outbreaks.

The perfect measles campaign

If 100% of the population could be immunized with a 100% effective vaccine, and entrance into the population of unvaccinated hosts could be eliminated, then measles could easily be eradicated. This situation is modelled by setting both $K_{Percent}$ and $K_{Effective}$ to 100% and $K_{Immigrate}$ to zero and is shown in Figure 3. Once the vaccination program is initiated, all hosts entering the system become immune at birth, and the disease disappears in a few iterations after infecting the increasingly few hosts that were too old to be vaccinated at the start of the simulation but had not yet contracted the disease. This process took 4 iterations (years) to complete. In 1978, the US Department of Health, Education and Welfare launched a measles eradication campaign that aimed to prevent *all* United States measles infections by Oct 1, 1982.[10] The model it employed that predicted a 4-year process of eliminating measles from the native population must have been similar to the model presented here. The health planners knew that immigrants would bring in sporadic cases of rubeola, but the hoped that a small number (less than 50 per year) could be isolated and controlled on a case-by-case basis.

The HEW scenario

If the United States could vaccinate its entire population with 100% efficacy as in the previous model, and a small number of non-immunized immigrants moved annually to the United States, could the Department of Health, Education, and Welfare's vision of measles containment be realized? By changing $K_{Immigrate}$ to 0.5% of the current host population, a very conservative estimate of the number of non-immunized immigrants, the model shows that measles epidemics continue indefinitely into the future (Fig 4). The amplitude of the outbreaks is smaller than the amplitude observed among the non-vaccinated population, but again the periodicity of outbreaks is similar (every 5 or 6 years).

It seems that as long as there is a continuous entry into the population of susceptible hosts, periodic outbreaks will continue. The high attack rate of measles ensures that once a very small threshold of susceptible hosts accumulates, as it will in any population with any immunization rate less than a full 100%, a very small number of measles cases introduced into that population can seed an epidemic. Careful examination of the parasite population shows that as population growth slows, the levels of the parasite population maintain their periodicity and amplitude but gain a small offset from zero.

One interpretation of this change is that measles becomes more of an

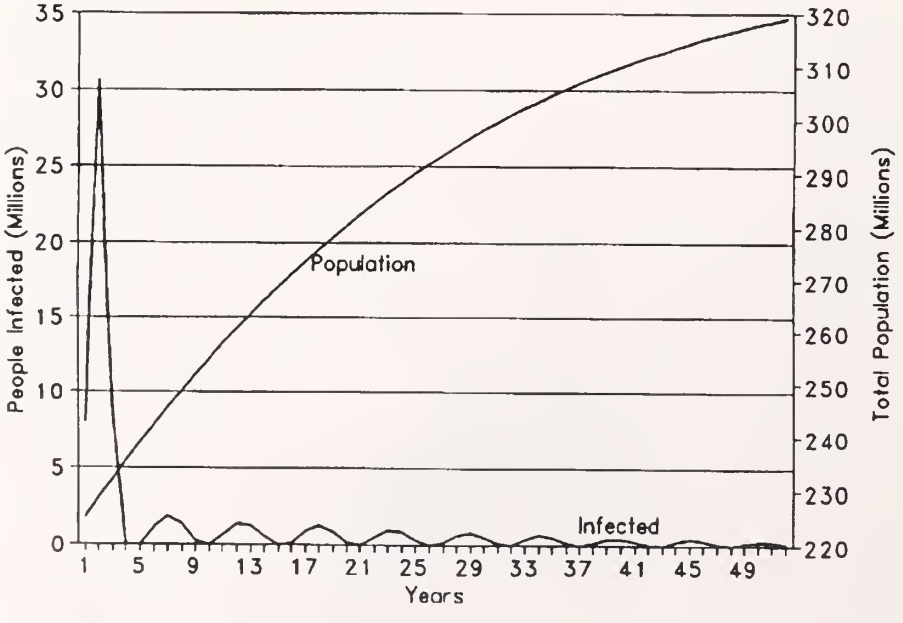

Fig 5. – Measles in a vaccinated population.

endemic disease as immigration levels reach a certain stability and magnitude (recall that immigration is just a percent of the total population, which stabilizes toward the end of the simulation). The immigration levels reach a balance between a high level that would allow measles to achieve maximum penetrance during exponential growth and a magnitude that would confine measles to the slower part of its growth curve.

A vaccinated population

Many outbreaks of measles during the 1980s occurred in populations that were more than 95% immunized.[10-13] Reports of those outbreaks suggested that many of the infections during those outbreaks occurred in people vaccinated before their first birthday. These outbreaks often occurred in relatively small communities and were traced back to a single index case. If this were the case for the general population, then Fig 5 shows how measles might progress.

With $K_{Percent}$ set to 98%, $K_{Effective}$ assigned 75%, and $K_{Immigrate}$ set to 0, the model predicts continuous, periodic outbreaks of measles. While amplitude of these outbreaks is much smaller than those observed in the previous models, the dynamics observed in those models seem to apply here as well. The amplitude of the outbreak is again proportional to the number of susceptible hosts introduced into the population (in this case the non-immunized and cases of primary vaccine failure) while the time course of the outbreaks is not. As population growth slows, the size of the outbreaks decreases. At no population level do the outbreaks disappear.

A well-vaccinated population

In response to the relatively high rate of observed primary vaccine failure, the CDC revised the measles vaccination guidelines. It now recommends that routine measles immunization be given to children at least 15 months old.[2] Several studies previously cited suggest that vaccines given at a later date can increase the seroconversion rates among children to well over 85%, and possible as high as 95%. To examine measles outbreaks in communities that have implemented the more modern vaccination criteria, this model sets $K_{Percent}$ to 98%, $K_{Effective}$ to 90%, and $K_{Immigrate}$ to 0 (Fig 6).

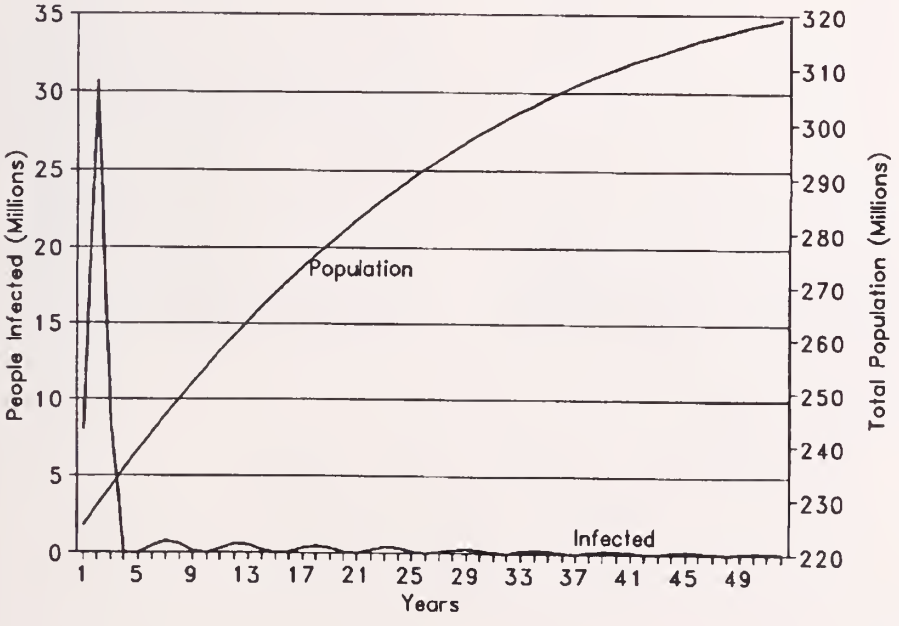

Fig 6.– Measles in a well-vaccinated population.

Outbreaks among similar populations have also been documented.

Like the previous model, this simulation shows periodic outbreaks with even more decreased amplitude. As population growth slows, the outbreaks become increasingly small. Importantly, the measles population still can increase once the small number of susceptible cases accumulated. Even in a well-vaccinated population, however, the virus quickly infects all the susceptible hosts on a periodic basis.

The inner city

The previous two models explore one common manifestation of modern measles outbreaks; this model explores the other.[14-17] Inner city population experience very low immunization rates among children too young to enter school. These same areas are also the target of substantial immigration (documented and otherwise) from regions with even less rigorous measles vaccination policies. Under the current immunization protocol, the inner city measles outbreaks can be explored by setting $K_{Percent}$ to 50%, $K_{Effective}$ to 90%, and $K_{Immigrate}$ to 1% (again, probably a large underestimate of immigration by non-immunized hosts). In this simulation, large outbreaks of measles will occur periodically when large numbers of non-immunized hosts are introduced into the population, and measles can become endemic in populations with sufficient immigration providing the sole source of susceptible hosts.

This model combines features of both non-vaccinated hosts and vaccinated hosts with immigration. Early in the simulation, population growth is rapid and new births supply most of the susceptible hosts. This rapid increase in measles targets allows high rates of parasitic growth to occur, and these high growth rates will eventually infect all susceptible hosts. In a stable population with a stable immigration (because immigration is a fixed fraction of the total population, and because the

population stabilizes toward the end of the simulation, the number of immigrants approaches a constant toward the end of the simulation), the parasite in these simulations can achieve continuous, low levels of infection punctuated by periodic outbreaks.

Conclusions

Patterns of disease. The eight measles outbreaks referenced in the preceding paragraphs hint at two trends in measles outbreaks in the post-vaccine era.[18] The first type of outbreak occurs among poor children too young to attend school. All states require measles immunization as a condition for kindergarten attendance which usually commences at age 5. In the United States, poor children younger than 5 years old are known to receive less medical care than richer ones. This often includes physical examinations, during which the measles vaccine would be expected to be administered. Hence, a large number of poor children in this country's inner cities are not vaccinated against measles.

The government's campaign against measles has largely removed it as an endemic disease from most of the country, and measles has recently become a rare disease. The only place where measles can be expected to reside regularly is in medical institutions, which tend to concentrate conditions normally spread out over a wide area on a local focus. The hospitals unfortunately are also the one place many of the poorer city residents bring their unimmunized children for medical care.

The other primary measles outbreak scenario occurs among secondary school children, most of whom are immunized. The relatively few children who refuse vaccination on religious grounds or experience primary vaccine failure have proven sufficient to sustain periodic outbreaks. These children were largely born after endemic measles was eliminated from the United States and were therefore unlikely to contract the virus during early childhood. As a result of mass vaccination, a larger proportion of non-immune individuals enter the older age strata. Unfortunately, measles morbidity increases dramatically among older children and adults. The immunization programs have had the effect of exposing the children who do contract measles to a substantially higher risk than they might have experienced had measles been allowed to infect almost all children younger than 5.

Lessons from the model. A few simple equations qualitatively generate patterns that resemble observed measles epidemiology closely. The periodicity of modelled outbreaks was shown to depend on the infectivity of the virus, and not on the magnitude of the susceptible population. Mass vaccination can lead to dramatically smaller parasitic outbreaks, but as long as some small number do not achieve immunity through vaccination, outbreaks will occur once a critical number of such hosts accrues. In stable populations that have a constant number of non-immune hosts introduced, the parasite population appears to reach endemic levels. Punctuated periodic outbreaks still occur, but the number of parasites does not drop to 0 between outbreaks.

If this model accurately represents some facets of measles in human populations, then any prospect for its elimination is suspect. The model suggests that any population that cannot achieve 100% immunity from vaccination will experience continued outbreaks. The outbreaks involve fewer hosts as the percent of the population immunized increases, but they nevertheless continue.

This model does not consider several important aspects of measles infection in the United States. Unlike observed measles outbreaks, distribution of both hosts and vaccines is dependent on overall density only; no spatial clustering is incorporated, and random association between all hosts is assumed. Religious groups exempt from vaccination often congregate together and can create pockets of susceptibility in an otherwise highly-immunized population.[19] Nosocomial infections given to children brought from a wide,

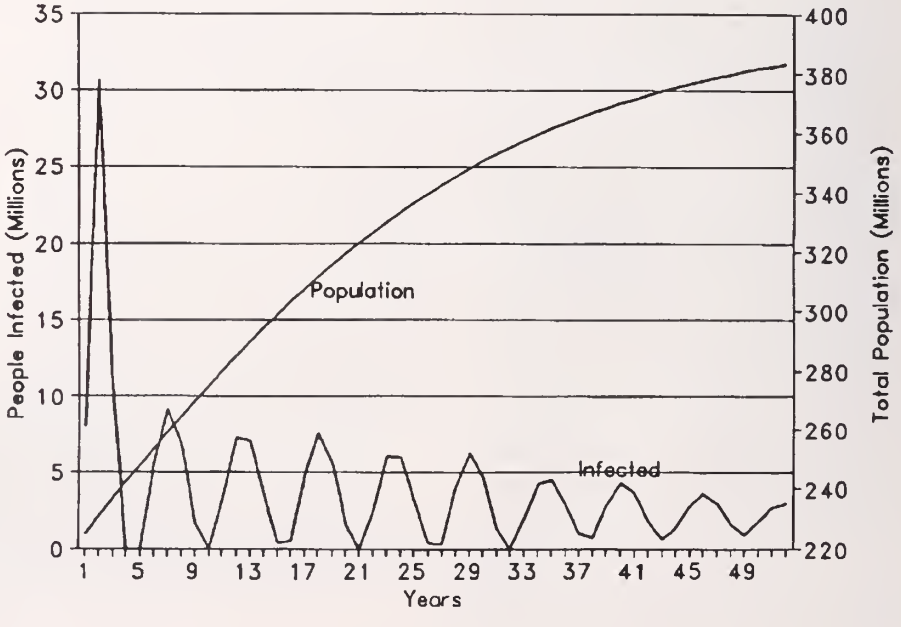

Fig 7.– Measles in the inner city.

disease-free area to one isolated site of high measles activity is likewise not considered. Different races and vaccination protocols elicit widely different seroconversion rates.[20,21] Finally, the class differences observed in the two major types of outbreaks clearly show that association among all hosts is not random.

Still, the model is scale-independent. It can be used equally well (or poorly) to examine more homogeneous sub-groups of the entire host population. In any case, the series of equations remains just a model. The observation that the curves it generates closely resemble patterns of measles outbreaks in different populations of the United States must be considered coincidental. The model can serve best as a guide to thought. If the few underlying assumptions of the model can be judged to reflect adequately on observed fact, and its many limitations are remembered, then its lessons should be considered when implementing a national measles policy.

Measles will not disappear in the manner of smallpox unless an exceedingly large and effective effort is mounted. This effort must be global, or continuous infusion of susceptible hosts will continue, and these hosts can start an outbreak that will spread to the few hosts experiencing vaccine failure. Mass vaccination can greatly reduce the magnitude of outbreaks, but the outbreaks will continue. The high infectivity of measles (and the lack of symptoms during the contagious phase) assures that index cases will escape isolation until after the disease has been spread.

References

1. Davis BD, Dulbecco R, Eisen HN, et al. In: *Microbiology*. 4th ed. Philadephia, PA: JB Lippincott; 1990:1017-1022.
2. Centers for Disease Control. Measles prevention: Recommendations of the Immunization Practices Advisory Committee. *MMWR*. 1989;38(S-9):1-17.
3. Hinman AR, Brandling-Bennett AD, Bernier RH, et al. Current features of measles in the United States: Feasibility of measles elimination. *Epidemiology Reviews*. 1980;2:154-170.
4. Aaby P. Malnourished or over-infected: An analysis of the determinants of acute measles mortality. *Danish Medical Bulletin*. 1989;36(2):93-113.
5. Edelstein-Keshet L. *Mathematical Models in Biology*. New York, NY: Random House; 1988:72-89.
6. Anderson RM, May RM. Directly transmitted infectious diseases: Control by vaccination. *Science*. 1982;215(26):1053-1060.
7. Anderson RM, May RM. Vaccination against rubella and measles: Quantitative investigations of different policies. *Journal of Hygiene*. 1983;90:259-325.
8. Levy DL. The future of measles in highly immunized populations: A modeling approach. *Am J Epid*. 1984;120(1):39-48.
9. Nokes DJ, Anderson RM. The use of mathematical models in the epidemiological study of infectious diseases and in the design of mass immunization programmes. *Epidemiology of Infection*. 1988;101:1-20.
10. Davis RM, Whitman ED, Orenstein WA, et al. A persistent outbreak of measles despite appropriate prevention and control measures. *Am J Epid*. 1987;126(3):438-449.
11. Chen R, Goldbaum GM, Wassilak SGF, et al. An explosive point-source measles outbreak in a highly vaccinated population: Modes of transmission and risk factors for disease. *Am J Epid*. 1989;129(1):173-179.
12. Gustafson TL, Lievens AW, Brunell PA, et al. Measles outbreak in a fully immunized secondary school population. *N Engl J Med*. 1987;316(13):771-774.
13. Nkowane BM, Bart SW, Orenstein WA, et al. Measles outbreak in a vaccinated school population: Epidemiology, chains of transmission and the role of vaccine failures. *Am J Public Health*. 1987;77(4):434-438.
14. Centers for Disease Control. Measles-New Jersey. *MMWR*. 1986;35(13):213-215.
15. Centers for Disease Control. Measles-Dade County, Fla. *MMWR*. 1987;36(4):45-48.
16. Centers for Disease Control. Measles-Los Angeles County, Calif. *MMWR*. 1989;38(4):49-57.
17. Centers for Disease Control. Measles Outbreak-Chicago, 1989. *MMWR*. 1989;38(4):591-592.
18. Markowitz LE, Preblud SR, Orenstein WA, et al. Patterns of transmission in measles outbreaks in the United States, 1985-1986. *N Eng J Med*. 1989;320(2)75-81.
19. Novotny T, Jennings CE, Doran M, et al. Measles outbreaks in religious groups exempt from immunization laws. *Public Health Rep*. 1988;103(1)49-54.
20. Dabis F, Waldman RJ, Mann GF, et al. Loss of maternal measles antibody during infancy in an African city. *International Journal of Epidemiology*. 1989;18(1):264-268.
21. Hanna JN, Macintyre AB, Worswick, et al. Seroconversion after administration of measles vaccine to central Australian aboriginal children at 9 months of age. *Medical Journal of Australia*. 1989;150:188-192.❑

Graduate nursing student writing contest winner

Music therapy: a means of reducing anxiety in the myocardial infarction patient

Jill White, RN, BSN, and Christine Shaw, RN, PhD, Milwaukee

THE ANXIETY that accompanies admission to the critical care unit when an individual has the presumptive diagnosis of acute myocardial infarction (MI) is a psychologically and physiologically stressful experience capable of imposing deleterious effects upon a patient's prognosis and recovery.[1-3] A number of holistic approaches have been developed to help reduce the effects of stress and increased anxiety levels. One example of these methods is music therapy.

Music therapy is the process of bringing about changes from undesirable, unhealthful, uncomfortable conditions to more pleasant ones by the deliberate use of music.[4] Music therapy has been further defined as "the controlled use of music, its elements, and their influences on the human being to aid the physiologic, psychologic, and emotional integration of the individual during the treatment of an illness or disability."[5] Properly chosen music is capable of eliciting a distinct relaxation response.[6]

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Anxiety in MI patients

Hospitalization for the treatment of an acute MI is generally considered a stressful experience.[7] An individual who is hospitalized for an acute MI may have had no previous hospitalizations, may have been relatively healthy all of his or her life, and now finds him or herself in an unfamiliar environment, surrounded by and attached to strange equipment, and forced to assume a dependent role. In addition, consideration must be given to the implications this diagnosis may have on future life. Many view life after an MI as represented by loss of strength, virility, ability to work, exercise, and participate in family activities.[8]

It has been suggested that most patients react to these numerous physical and psychological stresses by experiencing anxiety.[9-13] Anxiety may be defined as an emotional state consisting of feelings of tension, apprehension, nervousness and worry, and activation or arousal of the autonomic nervous system.[14]

Anxiety, as a nursing diagnosis, has a high incidence in the MI patient population.[11] It has been identified as the most immediate and most common psychological response to the medical diagnosis of acute MI.[15-17] Kim et al cited anxiety as the seventh most frequently identified nursing diagnosis, in a study of 601 identified nursing diagnoses in cardiovascular patient populations.[18]

Cassem and Hackett studied the various emotional responses of 441 patients hospitalized after enduring an acute MI.[9] They found that elevated anxiety levels were highest during the first 24 to 48 hours following admission, and then began to diminish. This is significant given that the 2 to 4 days after an individual has sustained an MI are a particularly vulnerable time for the damaged myocardium. Life threatening complications such as extension of the infarction, arrhythmias, congestive heart failure, and death, most commonly occur during this period.[19] Anxiety may potentiate these complications.

The major physical stressor encountered during an MI is a decreased blood supply to the myocardium, thus reducing oxygen supply to the tissues resulting in tissue injury or death. The anxiety experienced by the patient activates the stress response which in turn stimulates the hypothalmus, which stimulates the sympathetic nervous system and the anterior and posterior pituitary. Activation of the sympathetic nervous system results in release of catecholamines, which results in increased heart rate, blood pressure and myocardial oxygen consumption. In addition, the sympathetic nervous system, in cooperation with the hypothalmic-pituitary network, stimulates specific organs to increase serum glucose, aldosterone, sodium and chloride levels. The adrenal medulla is also stimulated by the sympathetic nervous system and is responsible for maintaining lasting sympathetic arousal. These stressors greatly increase the risk of further complications, including patient morbidity.[20-21]

In contrast, the relaxation response can result in a decreased level of sympathetic activity that decreases

cardiac workload and oxygen consumption.[22] In the case of MI patients, whose cardiac status is already compromised, these effects are of particular importance. Nurses need to collaborate with medical staff to identify methods, such as music therapy, that have been shown to be effective in reducing anxiety, thus minimizing its physiologic effect.

Music therapy

For centuries, music has been recognized for its therapeutic properties in healing the body and the mind.[23] Primitive man used music in various rituals to free the body of "evil spirits" believed to cause disease. Plato and Pythagoras believed that music, employed daily in a prescribed manner, would enhance one's health. Aristotle used "psychocatharsis," whereby after listening to music which raised the soul to ecstasy, individuals who suffered from uncontrollable emotions would relapse to their normal condition as if they had experienced a medical or purgative treatment.[6] From the Renaissance to the present, music and medicine have been integrated.

Recorded music was first used in the hospital in the late 1800s, after the invention of the phonograph.[6] At that time, recorded music was used to facilitate sleep, to allay anxieties that accompanied surgery, and to assist with the administration of local anesthesia.

In 1929, Duke University Hospital made a permanent commitment to the use of music in hospitals. They made provisions for patients to receive radio reception either through earphones, sponge-rubber-cushioned reception units, or wall-mounted speakers.

Following World War II, music therapy was more formally acknowledged. Music was used by the military in the treatment of wounded, disabled, or "shell shocked" veterans.

In the 1940s, dentists led the field in the use of music therapy. They recognized that music with earphones could effectively distract patients from their discomfort and the sound of the drill.[24]

Music is an orderly arrangement of sounds consisting of rhythm, melody, harmony, tone, and pitch. Pitch is the highness or lowness of a sound and is determined by the frequency of sound waves. Pitch acts on the autonomic nervous system. High pitch can cause tension, while low pitch tends to promote relaxation.[6] In addition, high pitch is usually associated with a bright or happy reaction, whereas low pitch usually connotes gloom or depression.[25] The tempo, or the beat, can also influence human response. When a tempo is faster than a human heart beat (80 to 90 beats per minute), tension increases. Tempos that are much slower than an average heart beat (40 to 60 beats per minute) may cause suspense. A tempo at approximately 60 beats per minute may be soothing.[6] Intensity is another variable that influences the overall effect of a piece of music. Music that is consistently loud becomes disturbing and a listener can become fatigued. On the other hand, soft sounds have a soothing effect and can be used for that purpose.[25]

Myocardial infarction patients would benefit most from music that promotes a relaxation response. This would include music that has a tempo of approximately 60 beats per minute and is predominantly low pitched.[6] Steady, simple and direct musical rhythm has been most effective in promoting relaxation. In addition, stringed instruments tend to be more relaxing than brass or percussion.[26]

Music has been shown to evoke certain feeling tones and moods in individuals. Music may be initially transmitted to the higher levels of an individual's brain where the sound becomes involved with emotion and abstract thought.[27] Gutheil reported the therapeutic value of music, particularly as it related to tension, relaxation and mood.[28] Prueter and Mezzano suggesteded that soothing music promoted more interaction in the counseling interview.[29] Brickman investigated effects of different types of music on moods of mentally ill patients.[30] He reported that slow musical rhythms had a sedative effect on patients.

Music may serve as an intervention to interrupt the stress response, which results in increased anxiety levels, in one of two ways. First, music may serve as a distraction from the stimuli that are causing the stress response,[30-32] or it may act directly upon the sympathetic nervous system.[6] Brody suggested that music appears to influence the brain network that determines emotional experiences by means of the limbic system.[33] Aesthetic pleasure received by the right brain may cause the pituitary gland to release endorphins. Further, the level of catecholamines seems to be lowered by soothing music, thus lowering heart rate, blood pressure, and free fatty acids levels.

Music is one method employed in relaxation therapy. Benson and Klipper proposed that the ability to relax is something each individual possesses.[34] It is a natural protective mechanism against "overstress." It allows one to turn off harmful bodily effects, to counter the effects of the fight-or-flight response. This innate response against "overstress" elicits bodily changes that decrease heart rate, lower metabolism, decrease respiratory rate, and return the body to what is most likely a healthier balance. The relaxation response and the stress response are considered mutually exclusive.[22] Thus, an individual is not able to elicit both responses simultaneously, and by eliciting the relaxation response, the individual has the opportunity to counteract the deleterious effects of the stress response.

Research of music therapy

Several studies have been conducted examining the effects of music therapy on anxiety of acute MI patients.

Downey and Flood proposed that intensive care patients may benefit from mental diversion using intermittent background music.[35] Their study demonstrated a decreased mortality rate of 8% to 12% after the music was added, as opposed to 20% prior to its inception. Webster alternated music and no music relaxation sessions for 10 individuals with a medical diagnosis of acute MI.[36] He concluded that a feeling of non-arousal, rather than arousal, was created immediately after a relaxation period. Further, he proposed that the use of music was more effective in producing a relaxed feeling than the sessions without music.

Bolwerk examined the effects of relaxing music on the reduction of state anxiety in 35 acute MI patients.[37] The experimental group listened to music on three consecutive days, while the control group had no intervention. Spielberger's State-Trait Anxiety Inventory (STAI) was used to measure state anxiety levels. Results exhibited significant reduction in the state anxiety scores of patients who listened to the music, as well as those in the control group. The post-treatment mean anxiety scores in the music group, however, were statistically significantly lower when compared with the non-music group.

Guzzetta also conducted a study to determine the effectiveness of relaxation and music therapy in reducing stress in patients in a coronary care unit, who were admitted with the presumptive diagnosis of acute MI.[2] Eighty subjects were divided into three groups, a control group, a relaxation group, and a music therapy group. Data analysis suggested that lowering apical heart rates and raising peripheral temperatures were more successful in the relaxation and music therapy groups than in the control group. In addition, the incidence of cardiac complications was found to be lower in the intervention groups, and most intervention subjects believed that such therapy was helpful.

Updike examined the physiologic and psychologic effects of music therapy on patients in coronary and surgical intensive care units.[38] The experimental group listened to sedative music. There was no control group. The results indicated a significant reduction in systolic blood pressure, mean arterial pressure and double product index (product of heart rate and systolic blood pressure divided by 100). In addition, it was suggested that patients' moods shifted toward a "more desirable state of well-being."

Davis-Rollins and Cunningham,[39] and Zimmerman, Pierson and Marker[40] examined the effects of music therapy on patients with a medical diagnosis of acute MI. The results demonstrated no statistically significant changes in the specified physiologic variables during the music periods. The data, however, suggested that there were psychologic benefits for the patients as a result of listening to the music.

Author's research

The author examined the effects of relaxing music on 40 individuals with a confirmed diagnosis of acute MI.[41] A two- group, pre-test/post-test experimental design was used. The experimental group listened to 25 minutes of relaxing music, while the control group was provided with 25 minutes of uninterrupted rest. The dependent variables examined included the state anxiety scores on Spielberger's STAI, heart rate and respiratory rate. The experimental group demonstrated statistically significant reduction in all three dependent variables when baseline and post-treatment measurements were compared. The control group showed a statistically significant decrease in post-treatment state anxiety scores only. When the post-treatment state anxiety scores of both groups were compared, however, the experimental group scores were statistically significantly lower than those in the control group. In addition, subjective data collected supported the notion that the music was more effective than the uninterrupted rest period in reducing feelings of anxiety.

Implications for practice

Music therapy may be a particularly effective choice of intervention for the acute MI patient. Studies that have been conducted examining the effects of relaxing music on this population suggest that it is an effective adjunctive therapy to the medical treatments currently utilized for this group. In addition, it takes very little time to implement, it is not expensive, and it is an intervention patients can use independently in a very short time. Furthermore, it demands little or no physical exertion.

Music therapy may be beneficial in a multitude of situations associated with the critical care setting. Not only could music therapy be used for the patient with obvious signs of anxiety, but it could be used for the patient who is having difficulty falling asleep due to the extraneous sounds of the unfamiliar environment, or during special procedures that are carried out in the critical care unit and special procedure laboratories. In addition, family members who are anxious about a loved one's condition, or other considerations during this time of crisis may benefit from the positives effects of music therapy. Music therapy may be useful in cardiac rehabilitation teaching sessions and support groups, as a means of either setting the mood or decreasing anxiety associated with the topics scheduled to be discussed.

During the past two decades, research studies examining the therapeutic effects of music have been increasing. Nurses, collaborating with their physician counterparts, have the opportunity to play a valuable role in the integration of music into the care of patients.[42]

References

1. Cassem NH, Hackett TP. Psychological rehabilitation ofmyocardial infarction patients in the acute phase. *Heart Lung*. 1973;2:282-290.
2. Guzzetta CE. Effects of relaxation and music therapy on patients in a coronary care unit with presumptive acute myocardial infarction. *Heart Lung*. 1989;18:609-616.
3. Wishnie HA, Hackett TP, Cassem, NH. Psychological hazards of convalescence following myocardial infarction *JAMA*. 1971;215:1292-1297.
4. Michel DE. *Music Therapy*. Springfield, IL: Charles C. Thomas; 1976.
5. Munro S, Mount B. Music therapy in palliative care. *CMA Journal*. 1978;119:1029-1034.
6. Alvin J. *Music Therapy*. London, Eng:J Baker Publications;1966.
7. Jiricka MK. The use of relaxation techniques in the acute phase of myocardial infarction. Unpublished master's thesis, Marquette University: Milwaukee, WI, 1982.
8. Cassem NH, Hackett TP, Bascom D, et al. Reactions of coronary patients to the CCU nurse. *Am J Nurs*. 1970;70:319-325.
9. Cassem NH, Hackett TP. Psychiatric consultation in a coronary care unit. *Ann Intern Med*. 1971;75:9-14.
10. Cassem NH, Hackett TP. Psychological aspects of myocardial infarction. Medical Clinics of North America 1977; 61:711-721.
11. Hackett T, Cassem N. Psychological management of the myocardial infarction patient. *Jour of Human Stress*. 1975;1:25-38.
12. Hackett T, Cassem N. Psychologic aspects of rehabilitation after myocardial infarction and coronary artery bypass surgery. In: NK Wenger, HK Hellerstein (Eds.), Rehabilitation of the Coronary Patient. 2nd ed. New York, NY: John Wiley & Sons;1984:437-451.
13. Spielberger CD. The nature and measurement of anxiety. In: CD Spielberger and R Diaz-Guerrero (Eds.), Cross-Cultural Anxiety. Washington, WA: Hemisphere Publishing Corp;1976:3-12.
14. Spielberger CD. Anxiety as an emotional state. In: CD Spielberger. ed. Anxiety: Current trends in theory and research (Vol. 1). New York, NY:Academic Press;1972.
15. Cay E, Vetter N, Philip A, et al. Psychological status during recovery from an acute heart attack. *Journal of Psychosomatic Research*. 1972;16:425-435.
16. Dellipiani A, Cay E, Philip A, et al. Anxiety after a heart attack. *Br Heart J*. 1976;38:752-757.
17. Vetter N, Cay E, Philip A, et al. *Journal of Psychosomatic Research*. 1977;21:73-78.
18. Kim M, Amoroso-Seritella R, Gulanick M, et al. Clinical validation of cardiovascular nursing diagnosis. In: M Kim, G McFarland, A McLane. eds. Classification of Nursing Diagnosis Proceedings from the Fifth National Conference. Philadephia, PA: JB Lippincott Co;1984:128-137.
19. Twerski A. Psychological considerations on the coronary care unit. *Cardiovasular Nursing*. 1971;7:65-68.
20. Lindsay AM, Carrieri VK. In: VK Carrieri, AM Lindsay, CM West. eds. *Pathopysiological Phenomena in Nursing*. 1986:301-318.
21. Riegel B. Acute myocardial infarction: Nursing interventions to optimize oxygen supply and demand. In: LS Kern. ed. *Cardiac Critical Care Nursing*. Rockville, MD: An Aspen Publication;1988:59-90.
22. Benson H, Kotch JB, Crassweller KD. The relaxation response: A bridge between psychiatry and medicine. Symposium on Psychiatry in Internal Medicine. 1977;61:929-938.
23. Cook J. Music as an intervention in the oncology setting. *Cancer Nursing*. 1986;9:23-28.
24. Taylor D. Music in general hospital treatment from 1900 to 1950. *Journal of Music Therapy*. 1981;18:62-73.
25. Parriott S. Music as therapy. *Am J Nurs*. 1969;69:1723-1726.
26. Altshuler IM. The value of music in geriatrics. In: EH Schneider. ed. *Music Therapy*. Lawrence, KS:Allen Press;1960.
27. Landreth J, Landreth H. Effects of music on physiological responses. *Journal of Research in Music Education*. 1974;22:4-12.
28. Gutheil E. Music as adjunct to psychotherapy. *American Journal of Pyschotherapy*. 1954;8:94-109.
29. Prueter B, Mezzano J. Effects of background music upon initial counseling interaction. *Journal of Music Therapy*. 1973;10:205-212.
30. Brickman H. Psychiatric implications of functional music for education. *Music Educator's Journal*. 1950;36:29-30.
31. McCaffery M, Beebe A. *Pain: Clinical Manual for Nursing Practice*. St Louis, Mo: CV Mosby; 1989:177;193-202.
32. Snyder M. Music. In: M Snyder. ed. *Independent Nursing Interventions*. New York, NY: John Wiley & Sons;1985:211-223.
33. Brody R. Music medicine. *Omni*. 1984;6:24-110.
34. Benson H, Klipper MZ. *The Relaxation Response*. New York, NY: Avon Books; 1976.
35. Downey G, Flood S. In this ICU, the downbeat helps the heartbeat. *Modern Hospital*. 1972:118:91.
36. Webster C. Relaxation, music and cardiology: The physiological and psychological consequences of their interrelation. *Australian Occupational Therapy Journal*. 1973;20:9-20.
37. Bolwerk C. The effect of relaxing music on state anxiety in the myocardial infarction patient. Unpublished master's thesis, Marquette University: Milwaukee, WI, 1986.
38. Updike P. Music therapy results for ICU patients. *Dimensions of Critical Care Nursing*. 1990;9:39-45.
39. Davis-Rollans C, Cunningham S. Physiologic responses of coronary care patients to selected music. *Heart Lung*. 1987;16:370-378.
40. Zimmerman L, Pierson M, Marker J. Effects of music on patient anxiety in the coronary care units. *Heart Lung*. 1988;17:560-566.
41. White JM. Music therapy: An intervention to reduce anxiety in the acute phase of myocardial infarction. Unpublished master's thesis, Marquette University: Milwaukee, WI, 1991.
42. Herth K. The therapeutic use of music. *Supervisor Nurse*. 1978; 9:22-23.❑

Graduate nursing student writing contest winner

Family protective thinking about cardiac events: nursing interventions to promote maintenance of family health behaviors

Lori A. Wastlick, RN, MSN, and Kathryn Hoehn Anderson, RN, PhC, Eau Claire

FAMILIES THAT HAVE a member experience cardiac events [ie, myocardial infarctions (MI) or bypass surgery] must adjust as families as well as individuals to the potentially life threatening event. The family adjustment process does not stop after the immediate crisis resolves. Lasting family changes–such as lifestyle changes of diet, exercise, and ongoing stress reduction–are required to maintain the health of both the affected individual and the health of the family. This new focus on the family in health care has developed out of clinicians' experience that illness affects the family life and that family dynamics often affect the progression of the illness in relation to compliance with medical and nursing health management regimes. Family nursing care can play a major role in assisting the family to maintain healthful family behaviors long after a cardiac event. This article presents background cardiac event and family developmental stage information related to cardiac events, the need for family health nursing intervention, a new concept called "protective thinking," nursing interventions that helped to interrupt protective thinking within actual clinical encounters, and outcome criteria to assess the effectiveness of family nursing interventions.

Lori A. Wastlick, RN, MSN, was a graduate nursing student and research assistant at the University of Wisconsin-Eau Claire at the time this article was written and submitted.. Kathryn Hoehn Anderson, RN, PhC, is an instructor in theDepartment of Family Health Nursing, at the University of Wisconsin-Eau Claire. This paper was a winning entry in the *Wisconsin Medical Journal*'s 1990 Graduate Student Nursing Writing Contest. Address reprints to: Lori Wastlick, 3911 Charleston Dr, Eau Claire, WI 54703. Copyright 1991 by the State Medical Society of Wisconsin.

Cardiac events

Each person who has suffered a cardiac event is a member of a family. The members of the family may or may not involve actual blood relatives, depending on each person's definition of their own family. The family examples in this paper include the traditional family structure of a married couple where one partner has experienced a cardiac event.

The Framingham Heart Study[1] found that almost 50% of myocardial infarctions (MI) occur in persons between the ages of 40 and 65. The majority of families experiencing cardiac events are, therefore, in the launching stage, during which developmental tasks deal with sending children into the world, attending to the couple's own interests and marriage once again, and focusing on the goals of retirement.[2] When a cardiac event affects the family, however, which most often happens to the father,[3] the expected developmental family patterns may be altered.

A cardiac event can greatly affect the family's developmental launching stage. Young adults who had plans to attend college with parental financial support may need to find alternate means of support. Parents may need to depend on the children who are trying to leave home. Therefore, this illness-forced dependency may alter the achievement of the expected developmental stage tasks. Parents may also need to again put off pursuing their own interests, consistent with developmental stage tasks, as a result of the family illness.

For example, spouses may have each been waiting for the children to leave home before actively seeking advancement within their employment or seeking pursuit of desired leisure activities. Now, the spouses may each only hope to stay alive or keep their current jobs throughout the unknown stages of cardiac event recovery. A cardiac event may threaten or change a family's ability to complete their desired goals. It may also pose a threat to other family members' health and well being as a result of the stress felt by all.[4]

The launching stage or retirement stage of the family can also have effects on the illness. For example, the ideal atmosphere of recovery for an MI involves minimal stress.[5] Families who are concerned over financial, employment, or launching issues, however, may experience significant stress during the recovery stage. Families who have been in the process of having children leave home may feel a lack of family support or conflict in the family, which may similarly elevate stress levels.[6] Family members who anticipated financial security in their retirement years may need to seek post-retirement

employment.

The above examples are ways the cardiac illness can affect the family and the family can affect the illness. Nursing interventions can help families to deal with the effects of the illness on the family and the effects of the family of the illness recovery.

Nursing intervention

The purpose of family nursing is to optimize the health and general well being of patients and their families as they respond to health events.[7] The goal of family nursing, according to Betty Neuman's[8] Systems Theory, is to assist families develop a balance between stressors and reactions to stressors to preserve the integrity of the family. The result for the family is a heightened awareness of the influence of stressors on the family and increased functioning within the family, and thus a greater focus on family health as well as individual family member health. Nurses accomplish this goal by assisting families and individual family members to understand the dynamics of either the illness or cardiac event, to recognize their response behaviors, and to find effective coping mechanisms. The methodology provided by nurses to assist families in recognizing illness and behavior dynamics and to establish facilitative coping mechanisms is called nursing intervention.

Family recovery

The family nursing clinical experiences described below resulted from the first author's interaction with two families that had experienced cardiac events. One family had experienced the husband's bypass surgery 12 months prior to the clinical experience. The second family experienced the husband's MI in the past 12 months and the wife's bypass surgery 6 months before the nursing intervention. Each family consisted of a husband and wife and were in the developmental stage of retirement.

Families who have had an MI a time ago (ie, at least 6 months previous) have ideally entered into the total integration phase of MI recovery.[9] The total integration phase means that the family has returned as closely to pre-cardiac event functioning as possible, assuming medically recommended lifestyle changes have been incorporated into the functioning of the family. The two case families, however, were assessed as having returned to almost the exact pre-cardiac event functioning in regard to diet, exercise, and daily functioning; they were no longer following post-cardiac event teaching guidelines. The motivating factor for the families' return to pre-cardiac event functioning was assessed to be leniency with regard to rehabilitative cardiac measures. This phenomenon of leniency is labeled "protective thinking."

Protective thinking

Protective thinking occurs when enough time has passed after a health event that allows the patient to either subconsciously or consciously minimize the seriousness of the event from their memory. The family adopts this view. This allows the family members to return to pre-health event behaviors without ongoing consideration for health, safety, and recovery facilitated by recommended medical changes in lifestyle. In the case of a cardiac event, the family feels safe and believes that the affected person is currently well and medically stable and will not experience another cardiac event. Thoughts of the potential for future complications are suppressed by the family and the need for ongoing monitoring seemingly is overlooked. This thinking allows the family to relax on measures which may help keep the affected individual and the family free from future cardiac events.

Protective thinking differs from denial in that the occurrence of the event is not denied. The individual and family have not only accepted the occurrence of the event, but have, most likely, initially made lifestyle changes to accommodate for the event. The passage of time, however, allows the individual and family to suppress the serious nature of the event which was previously the motivating factor for the lifestyle changes. This belief allows the family to become lax about the need to continue recommended lifestyle changes and coping strategies.

The two families assessed for protective thinking recognized that their lifestyle changes since the affected person's cardiac event had been returning more and more to pre-cardiac event practices. The nursing intervention of questioning and discussing the seriousness of the cardiac event, and subsequent family behaviors and health practices, facilitated positive family change. On assessment at subsequent visits, the family nurse noted improved activity, attention to diet and medication schedules, increased family communication and attention to positive coping strategies.

Interventions used

The first set of nursing interventions the author used to explore family protective thinking is interventive interviewing.[10,11] Interventive interviewing includes the use of questioning to explore family and illness dynamics. Types of questions and the area of family experience examined with each type of questioning by the nurse are:

- *Lineal questioning.* Families were assessed in relation to diet, exercise, medication, coping, communication patterns, and family beliefs surrounding the occurrence of the cardiac event.
- *Future questioning.* Families were asked to explain what they would do if the affected person had another cardiac event.
- *Hypothetical questioning.* Families were encouraged to explore thoughts regarding what they would have done if the affected person had died.

- *Relationship and difference questioning.* Families examined how their relationships differed before and after the cardiac event.
- *Behavior effect questioning*: Families became aware of the other family members' feelings when the affected person did not follow his or her prescribed health regimen, and thus consider the effect on other family members.
- *Normative questioning.* Families were informed of the common theme for families to fall away from health promotion behaviors when the fear of the cardiac event subsided within the family.
- *Embedded suggestion.* From the above questions, the families received an embedded suggestion of returning to health promotion behaviors.

Post-session interventions to encourage health promotion behaviors included: encouragement of one family to follow-up on a call they made to start an exercise program; encouragement of a family to come up with a way to remind the affected person to take medications as scheduled throughout the day (ie, alarm wrist watch, take with meals and at bedtime); informing families of heart healthy cookbooks in the libraries and bookstores; and informing families of the benefit of shared communication and stress-reduction behaviors.

Family outcomes

The desired outcome for the nursing interventions involved family changes in health practices. The evaluation of the outcome with the family was accomplished through the verbal report by family members of changes in health regimes.

The families noted changes in their health practices since the nurse began visiting with them. One family had pursued an exercise program. The same family reported that a member who had difficulty remembering to take his medications, took them as prescribed for 4 days. Both families expressed interest in receiving information regarding heart healthy cookbooks. Both families recognized the importance of maintaining medically recommended lifestyles regardless of the current "well" status of the affected individual and family members.

Conclusion

The information presented throughout this paper suggests that family compliance to health regimes in relation to cardiac events is more a factor of psychosocial elements involving family dynamics than lack of family education. Family nurse interventions using interventive interviewing[10,11] and health promotion discussions to encourage examination of family protective thinking was implemented by the family nurse. Further research is necessary to validate the use of family nursing intervention and the case study reports about protective thinking. The nursing intervention needs to focus on the family's beliefs surrounding mortality as well as the actual health and family behaviors. Using family nurse interventive questioning helps to reduce the blocking effect of protective thinking on the implementation of family health behaviors. The repeated reminder to families that a cardiac event, such as an MI or bypass surgery, is not necessarily an isolated occurrence is suggested to be the element needed to stimulate family compliance with health regimes.

References

1. Castelli WP, Garrison RJ, Wilson, PW, et al. Incidence of coronary heart disease and lipoprotein cholesterol levels: The Framingham Study. *JAMA*. 1986:256:20;2835-2838.
2. Duvall EM. *Marriage and family development*. Philadelphia, PA: JB Lippincott Co; 1977.
3. American Heart Association. *1988 Heart Facts*. Dallas, TX: American Heart Association; 1988.
4. Tomlinson PS. Applying family stress theory to nursing practice. *Nurse Practitioner*. 1986. 11:10;78-81.
5. Brunt JH. Intervening with families at the launching stage and myocardial infarction. In: M Leahey and LM Wright. *Families and life threatening illness*. Springhouse, PA: Springhouse Corporation;1987: 271-281.
6. Boss, P. *Family stress management*. Newbury Park, CA: Sage Publications, Inc;1988.
7. Nyamathi, AM. Perceptions of factors influencing the coping of wives of myocardial infarction patients. *J Cardio Nursing*. 1988:2:65-76.
8. Neuman, B. Analysis and application of Neuman's Health Care Systems Model. In: IW Clements and FB Roberts. *Family health: a theoretical approach to nursing care*. New York, NY: John Wiley and Sons, Inc;1983:353-366.
9. Burgess A, Hartman C, Lerner D. Intervening with families at the launching stage and heart attack recovery. In: M Leahey and LM Wright. *Families and life-threatening illness*. Pennsylvania, PA: Springhouse Corporation;1987:282-296.
10. Tomm K. Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*. 1987:26;167-183.
11. Tomm K. Interventive interviewing: Part III. Intending to ask lineal, circular, strategic, or reflexive questions? *Family Process*. 1988:27;1-15.❑

Correction

THE JUNE 1991 EDITION of the *Wisconsin Medical Journal* failed to include the figures accompanying the article "All-terrain vehicle injuries in Central Wisconsin: a continuing problem," by Dean Stueland, MD, and Robert Aldrich, PA-C (*Wis Med J* 1991;90(5):275-278). The figures can be found below.

The *Wisconsin Medical Journal* apologies to the authors and their readers for any inconvenience or confusion the error may have caused.❑

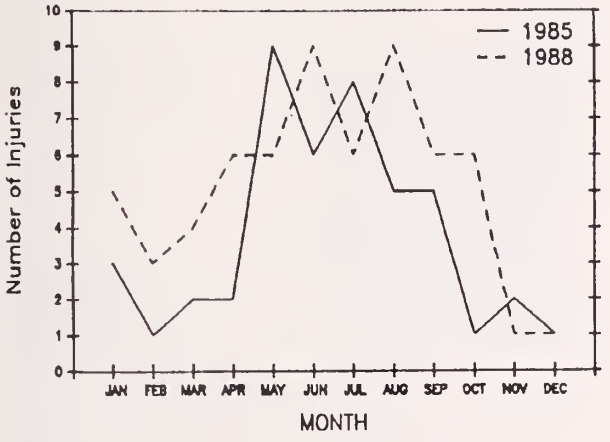


Fig 1.–ATV related victims by month for 1985 and 1988.

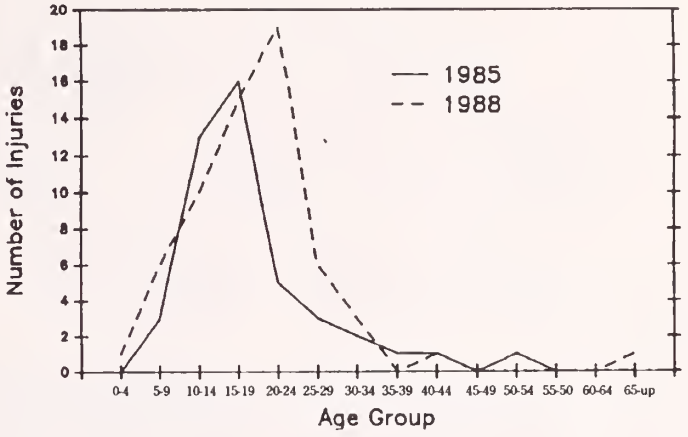


Fig 2.–ATV injuries by age for 1985 and 1988.

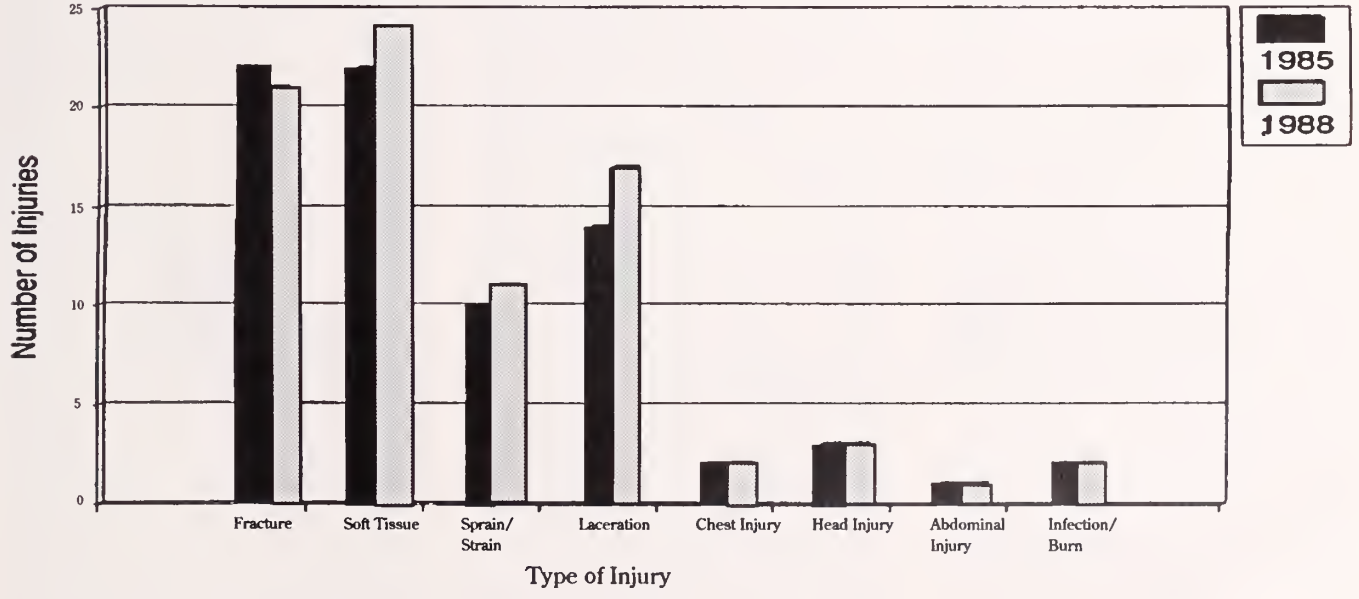
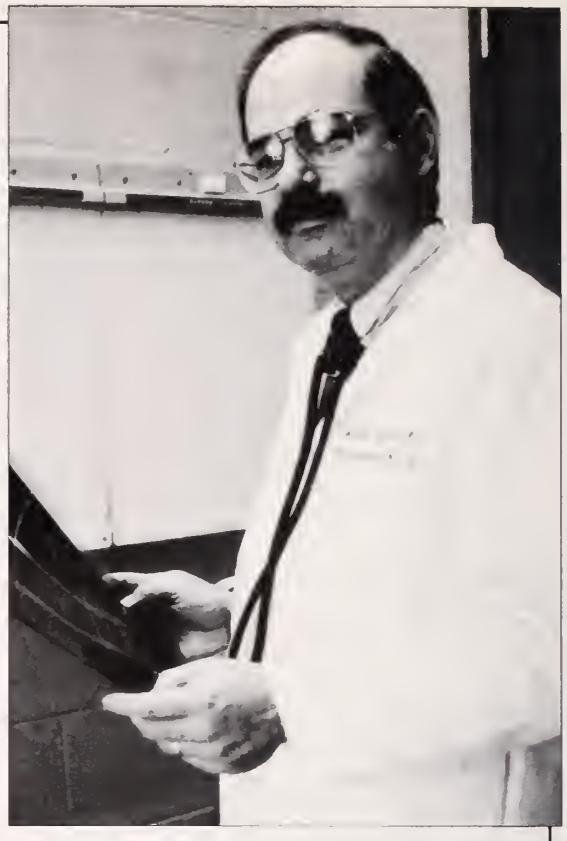


Fig 3.–ATV related injuries in 1985 and 1988.



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Public health

The Wisconsin Farmers' Cancer Control Project

Douglas Reding, MD; Henry Anderson, MD; Karen Lappe, RN; Lawrence Hanrahan, MS; Linda Haskins, Madison

AGRICULTURAL EMPLOYMENT involves considerable physical activity, often in a presumably healthy outdoor environment. Stereotypical farmers are depicted as physically fit, independent individuals who exercise regularly and breathe clean air, free of the toxic chemicals that poison urban life. Studies have shown that farmers do live longer than non-farmers. Their greater longevity, however, obscures the fact that farmers experience significant occupational-related disease, injury, and death. National Safety Council study reports reveal that farming is the most dangerous occupation in the United States.

Douglas Reding, MD, and Karen Lappe are with the Marshfield Medical Research Foundation, National Farm Medicine Center, and Henry Anderson, MD, Lawrence Hanrahan, MS, and Linda Haskins, are with the Wisconsin Department of Health and Social Services, Division of Health, Bureau of Community Health and Prevention, Section of Environmental and Chronic Disease Epidemiology. Address reprints requests to: Patrick Remington, MD, Wisconsin Division of Health, 1 W Wilson St, Madison, WI 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin.

In addition to high farm related injury, there are preventable or controllable illnesses which occur in excess in the farming population. Risk of cancer is a major issue. Although farmers as a group tend to smoke tobacco less and, therefore, have fewer smoking-related cancers, epidemiologic studies have identified an excess of deaths among this group from such diseases as non-Hodgkin's lymphoma; and skin, prostate, and brain cancers.[1]

Background

The agriculture industry has a dramatic effect on the welfare of Wisconsin. In 1989, there were approximately 81,000 farms employing 244,588 people in Wisconsin.[2] This represents approximately 5% of Wisconsin's population. Some counties are more dependent on farming than others (Fig 1). Wisconsin's cash receipts from all farm commodities in 1989 totaled $5.5 billion. The state was the eighth most agriculturally productive in the nation.[3] These numbers indicate the significant effect the health of the farming population can have on the state. Farmers' health status can not only drastically change the state's economic condition, but also its mortality and morbidity rates.

Farming is more than an occupation; it is a lifestyle. The risk of cancer death, affects not only the farmer but his or her spouse and their children as well. Exposure to potentially carcinogenic agents is a serious issue for farmers and farm families who are continually exposed to these agents because the farm serves not only as work site, but as home and recreational site as well.

A 1975 study from Wisconsin described a cluster of cases of lymphocytic leukemia which seemed to be closely related to a town creamery near which the patients lived[4]. A case control study of non-Hodgkin's lymphoma has shown farming to be more common among cases than controls, especially for those farmers under 65 years old. Risks among young farmers (those younger than 65) seem higher in counties that have more general agricultural activities, small grain production, and acreage treated with insecticides. Further studies of death certificate data in Wisconsin have found farmers to be at elevated risk for multiple myeloma, especially those in counties high in fertilizer use and acreage treated with insecticides. Using Wisconsin non-farmers as the standard population, farmers

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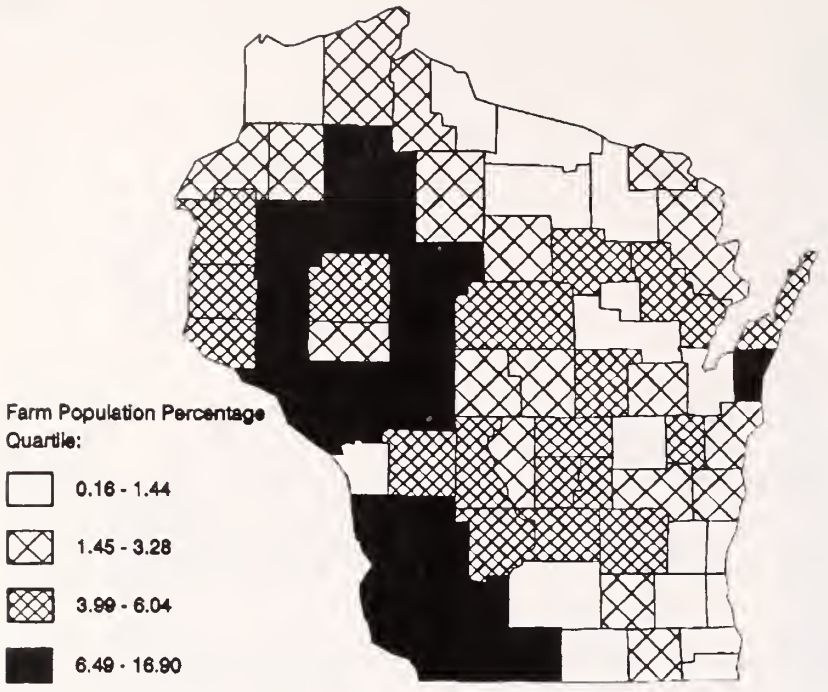

Fig 1. –Percentage of county population employed as farmers in Wisconsin, 1980.

Continued from preceding page
experience excess proportional mortality or odds ratios for cancers of the stomach, prostate, and eye; and for Hodgkin's Disease, leukemia, and non-Hodgkin's lymphomas (Fig 2).[1,5,6]

Access to health care

In addition to the direct cancer risk possibly attributable to farm work, farmers' risks may be compounded by health care access barriers which may delay diagnosis and treatment of cancers. Such barriers may contribute to excess mortality from non-occupational as well as occupational cancers.

The National Cancer Institute (NCI) has estimated that 75% of all cancer deaths could be avoided by the elimination or reduction of known cancer risk factors. Accordingly, NCI has established a nationwide policy to reduce cancer incidence by 50% by the year 2000.[7] Specific cancers for which early detection practices are recommended include those of the breast, cervix, colon and rectum, and skin. Methods critical to promoting cancer prevention and early detection include the following:

1. Educating patients regarding personal risk factors, screening guidelines, and the efficacy of prevention and early detection.
2. Enhancing patient attitudes by reducing barriers and concerns regarding cancer control practices.
3. Promoting positive behavioral changes with strong specific medical advice.
4. Offering social support and reinforcement for help in behavioral changes.

The actual barriers for an agricultural population take several forms. To promote early detection activities and increase cancer survival among farmers, these barriers need to be overcome.

The first group of barriers includes the availability of appropriate diagnostic methods, often measured by factors such as the concentration of physicians per county and the number of mammography machines in an area. Once diagnosis has been made, barriers to treatment include the distance to a cancer treatment hospital or to an oncologist. Insufficient health professional's knowledge of early cancer detection practices may also be a barrier.

A second group of barriers reflect individual circumstances and may be more varied from person to person and region to region. These include limited or non-existent insurance coverage, inability or unwillingness to meet co-payments for primary care, and similar financial considerations. Personal barriers include individual failure to comply with healthy practices such as: protecting the skin from sun exposure; a high fiber, low-fat diet; or avoidance of exposure to toxic agents.

Final types of barriers which may be more difficult to quantify include socio-cultural phenomena such as: the importance of individualism and self-reliance to the farmer; the farmer's familiarity with living or working in discomfort including pragmatic attitudes which tend to lead to ignoring signs and symptoms of disease; and a tendency to be outside the existing stream of disease prevention education and information services.

The project

The Centers for Disease Control (CDC), National Institute for Occupational Safety and Health (NIOSH) recently awarded the National Farm Medicine Center of Marshfield a $2.1 million, 3-year grant to fund the Wisconsin Farmers' Cancer Control Project. This project was established to assess and overcome the farm population's barriers to cancer screening and prevention. Through this project, new educational programs will be established, and specific intervention programs incorporated into existing health care systems. A special health screening package for low income people may be one of the products of this study. The targeted cancers include lymphoma, and cancers of the breast, colo-rectal and skin.

The Marshfield Medical Research Foundation (MMRF) will be

collaborating with the Wisconsin Department of Health and Social Services to study possible barriers the farm population faces in receiving health information and care. The Department of Health and Social Services group will compare mortality rates and stages of cancer diagnoses between farm and non-farm populations.

The project will identify barriers, in large part, through surveys of health care providers, farmers, and farm family members. This aspect of the study is scheduled to begin in September. With the cooperation of study subjects, researchers will reach more than 3,000 people. The intervention projects are scheduled to start later this year.

The National Farm Medicine Center is a program of Marshfield Medical Research Foundation and Marshfield Clinic. Established in 1981, the Center addresses the disease and injury problems confronting rural Americans.

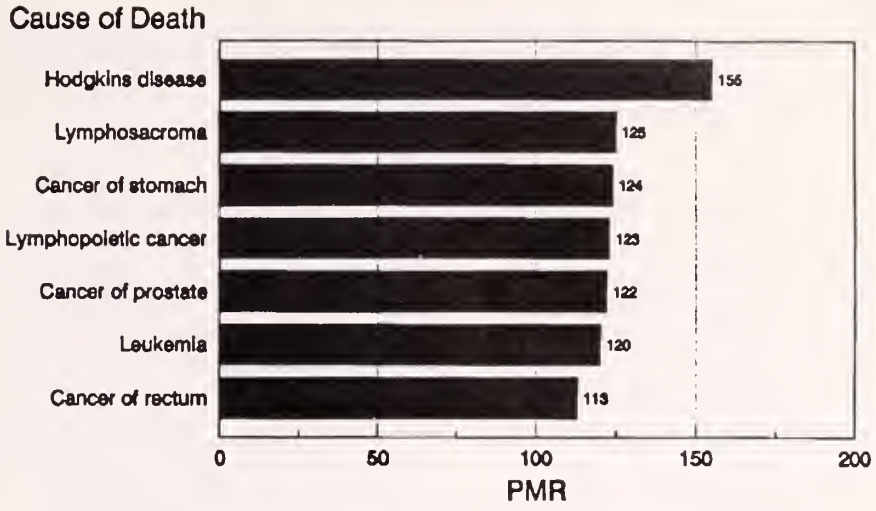

Fig 2. –Proportionate mortality rations for selected cancers, Wisconsin male farmers, 1968-1976.

Comment

The NIOSH Cooperative Agreement Program for Demonstration Cancer Control Projects for Farmers has been enthusiastically received by health care professionals in Wisconsin. This project will increase awareness of the significance of health promotion and disease prevention in the farming population from an economic as well as public health perspective. Farm families are the strength of rural communities, and the untimely or unnecessary death or extensive treatment regime of any adult or child due to cancer puts a burden on family members, neighbors, local business and, frequently, the church. Looking beyond Wisconsin's farming population, we hope that the efforts of the NIOSH cooperative agreements will lend significant leadership and guidance to health care providers throughout the United States, especially in those areas where economic livelihood depends heavily on agricultural production.

Funding from the NIOSH cooperative agreement is intended to support specific assessment, education, and intervention projects which may ultimately result in a reduction of real or perceived barriers between the farming population and appropriate cancer prevention, screening, treatment and rehabilitation. The cooperative nature of these endeavors will ensure the interaction of specialists from NIOSH, the health care professions (medicine, nursing, public health, occupational and industrial health), and the farming community itself (farmers' cooperatives, university cooperative extensions). Interaction among these entities fostered through the NIOSH cooperative agreements holds a promise of significant findings which will move us toward the achievement of specific and overall aims associated with decreased cancer morbidity and mortality.

Acknowledgments: Part of this work was supported through a cooperative agreement from the National Institute of Occupational Health and Safety, Centers for Disease Control (#U03/CCU506135-01).

References:

1. Saftlas A, Blair A, Cantor K, et al. Cancer and other causes of death among Wisconsin farmers. *Am J Ind Med.* 1987;11:119-129.
2. Wisconsin Agriculture Statistics Service, *1990 Wisconsin Agricultural Statistics.*
3. Wisconsin Agriculture Reporting Service, *1991 Wisconsin Agricultural Statistics.*
4. Bartsch DC, Springher F, Falk H. Acute nonlymphocytic leukemia. an adult cluster. *JAMA.* 1975;232:13.
5. Cantor K. Farming and mortality from non-Hodgkin's lymphoma: a case-control study. *Int J Cancer.* 1982;29:239-247.
6. Cantor K, Blair A. Farming and mortality from multiple myeloma: a case-control study with the use of death certificates. *JNCI.* 1984;72(2).
7. National Cancer Institute, Division of Cancer Prevention and Control: Cancer Control Objectives for the Nation 1985-2000. *NCI Monograph 2.* 1986.

Series coordinators

The Wisconsin Division of Health's Henry Anderson, MD, chief of the Section of Environmental and Chronic Disease Epidemiology, and Patrick Remington, MD, are coordinating this series for the *Wisconsin Medical Journal.*

Physicians Insurance Company of Wisconsin: state of the corporation

THE COMPANY ENTERS its fifth year of operation having devoted much of last year to establishing a clear vision for the future and implementing organizational and staffing changes to help guide it in that direction, and in February 1990, the Board of Directors established the following mission:

"While continuing to meet or exceed the expectations of our shareholders, Physicians Insurance Company of Wisconsin will become a major multi-line, multi-state insurance company."

The board recognized that, while providing professional liability insurance to physicians at an appropriate price, the company is vulnerable to competitors whose only distinction is low price. To meet this challenge, the company will spend the next several years entering new markets and expanding the lines of business to give the company stability.

To this end, a holding company was formed to control a number of subsidiary companies. The products and services offered by these companies aim to enhance physicians' and surgeons' market and will attract business from non-physician markets.

Management also evaluated employee resources, and took steps to augment the experience and expertise that currently existed in the company by adding seven management and several technical positions.

One of the successes that has differentiated PIC-Wisconsin from the competition is the personal relationships that have developed within the industry. In most of these relationships, the company has been able to demonstrate a responsiveness and sensitivity. Personal relationships are the cornerstone of what the company hopes will make a difference as more and more players enter the professional medical liability insurance market. The following are some of the relationships strengthened during the past year:

State Medical Society–The company's relationship with the SMS is excellent. The vice president of underwriting participates as a liaison to the Society's Medical Liability Committee, the marketing department actively interacts with the SMS field staff on an ongoing basis, and communication at the executive levels remains strong.

Agents–The company's relationships with its agency force continue to grow stronger, especially as one-on-one relationships are developed with the agents. Several new products and features will solidify the company's current agency force.

Family practitioners–The rapport with the Wisconsin Academy of Family Physicians began in 1989 when rate indications called for a 66% increase in the premiums paid by family practitioners doing obstetrics. Intensive dialogue between the company and the Academy resulted in an acceptable compromise. The Academy chose, at its most recent board meeting, to endorse PIC-Wisconsin's new prenatal care program.

Anesthesiologists–The company has had ongoing communication with the leadership of the anesthesiology specialty society, resulting in the implementation a credit program for that group.

Medical group managers–During 1990, PIC-Wisconsin became an affiliate member of the Medical Group Management Association, and has developed excellent lines of communication with its leadership.

PIAA–In June, the company gained representation on the Board of Trustees of the Physician Insurers Association of America (PIAA), an organization of physician-owned and physician-directed companies. Active involvement in the PIAA has resulted in a number of excellent contacts within the professional liability industry.

OCI–The company's longstanding approach of full disclosure to and personal contact with the staff of the Office of the Commissioner of Insurance (OCI) has resulted in excellent response time to submissions and inquiries. The company's leadership in the industry is recognized and the vice president of claims was named to their Risk Management Oversight Committee and the PCF Claims Committee.

Finances

Financially, the company remains strong, with more than $19 million in stockholder's equity to support our $24 million in premium writings. Assets grew to almost $75 million, more than 93% in cash and securities. For 1990, our actuaries have declared reserves to be reasonable, with reserve levels at 105% of their indicated level. The company finds itself in the enviable position of being able to fund growth while still reducing rates by 9.5% for 1991. Last year also marked entry into the reinsurance market, and over the course of the last 7 months, a treaty was negotiated to share higher claims with the reinsurers. This treaty will be placed entirely with Lloyd's of London. To the company's knowledge, this is the first time a physician-

owned company has been able to achieve a treaty entirely supported by Lloyd's.

In November, the company completed conversion to its new computer system, and while normal complications from the conversion have caused service to suffer temporarily, the new system promises superior performance.

Finally, the company either developed or implemented a number of new features and benefits, including:

- expanded coverage for physicians acting in the capacity of medical directors;
- development of a pre-retirement DDR benefit, named PRIME;
- re-classification of physicians using laser technology to their original class;
- reduction in the retirement age from 60 to 55 for our death, disability and retirement benefit;
- declaration of a 10% policyholder dividend; and
- reduction in rates by 9.5% on a mature basis.

The prospective

The company continues to improve the products and services currently available to policyholders by investing in people and equipment that help to move the company into new markets. Premiums and policyholders continue to grow, and loyalty by the insureds is evidenced by nearly a 99% renewal rate.

One of the company's most important projects is the review of its internal organizational structure. To assure that staff is in the best position to serve policyholders, the company continues to look for ways to improve. Researching the applicability of the team concept to the company has been a major effort by the management team.

Serious changes have been made in risk management, merging the efforts of claims, underwriting and loss prevention into a focused, policyholder-level program. The claims department staff strives to become personally acquainted with and provide support to either the policyholder or defendant by attending mediation and trials whenever possible.

Finally, there are a number of features and benefits being evaluating solely for the physician policyholders, many of which the company plans to introduce in 1991. As in years past, the conceptual effort begins early in the year, and development matures as the next renewal period approaches.

Conclusion

The company continues to evolve, to look for different ways of doing things, and to invest in the creativity and enthusiasm of its employees. While striving to maintain leadership and grow beyond current accomplishments, the company will preserve the values that have given it stature among physicians. At a recent meeting, those values were committed to writing:

> Through the excellence of our people and utilizing sound business practices, we will respond to opportunities in the marketplace while maintaining our profitability and position of leadership.
>
> This statement recognizes the need for the enthusiastic dedication of our people. We are committed to the following values:
>
> - professionalism
> - responsibility
> - customer satisfaction
> - good corporate citizenship
> - the expression of creativity, and
> - a fulfilling work environment.

Above all, PIC-Wisconsin prizes honesty, integrity and a commitment to quality in every endeavor.❑

New statewide information and referral service coming soon

First Step, a new statewide information and referral service, will begin operating this summer. Developed by the Wisconsin Council of Developmental Disabilities, the Department of Health and Social Services, Division of Community Services and the Birth to Three Program, in cooperation with the Division of Vocational Rehabilitation, the toll-free telephone service will provide families and physicians with a statewide network of information on services and resources available to children with special needs. The program is targeted to those birth to 6 years old.

Physicians and other health care practitioners have been asked to inform the First Step program of specialized services they provide to children with special needs so that their services can be listed in the directory. For more information or to obtain a registration packet, call 1-800-642-STEP, or in Madison, (608) 266-5148.❑

HCFA tries to balance the budget with RBRVS

SMS MEMBERS should have received a letter dated June 19, 1991, asking for help and participation in preventing the Health Care Financing Administration (HCFA) from implementing a 16% reduction in the Medicare conversion factor (the dollar amount used to calculate an actual Medicare payment). On June 5, 1991, HCFA published the Notice of Proposed Rule Making (NPRM) on the new payment system for physician services. The new Medicare payment system uses a payment schedule that reflects the resource-based relative value scale (RBRVS) developed by researchers at the Harvard School of Public Health.

As you are aware, the RBRVS establishes a relative value unit (RVU) for every procedure code that is based on measurement of associated physician work, practice costs and professional liability costs. Each of these components is then multiplied by a geographic practice cost index (GPCI, or "gypsy") to establish the final locality-specific RVU. Reimbursement, however, depends on the dollar conversion factor that translates the final RVU into actual Medicare payment. For 1992, HCFA has proposed a conversion factor which, at $26.873, is 16% less than expected.

This conversion factor reduction means that many projected payment levels are much lower than those reflected in previous impact simulations. The NPRM also contains HCFA's projections of the overall effects of the proposed payment schedule at the specialty and state level.

Last week, SMS President Cyril M. "Kim" Hetsko, MD, President elect William Listwan, MD, and Secretary-General Manager Thomas L. Adams, CAE, attended a special meeting with the AMA Board of Trustees in Chicago to plot federation strategies to substantially amend the draft rules. In addition to urging all SMS members to contact Rep. Jim Moody, HCFA and their Congressional representatives, SMS strategies include: meeting with every member of the Wisconsin Congressional delegation in their home districts; contacting HCFA directly; working with the Medical Group Management Association; discussion by the SMS Board; and a series of Medigram articles over the next few months, highlighting Medicare policy changes.

The reduction proposal, however, is only a proposal. All elements of the NPRM are subject to change with the final rule in October. For more information, contact the SMS Division of Medical Policy and Practice at 1-800-362-9080 or (608) 257-6781.❑

Private insurance billing issue heats up

AS REPORTED IN THE March 13, *Medigram*, the SMS Office of Legal Services is hearing from clinics and medical offices across the state that some health insurance carriers are encouraging patients not to pay the balance of a bill paid at the "usual customary and reasonable" (UCR) rate by the insurer.

Although not a new approach, a trend among carriers seems to be developing where the carrier notifies patients that they need not pay in excess of the carrier's payment and that the carrier will assist in defending the patient if the medical office attempts to collect the balance owed. Medical offices may be forced to take formal action against patients to collect on bills where the balance between the UCR rate and what is billed is owed.

Unless a contract to the contrary has been signed, a physician or clinic is under no legal obligation to accept the insurance reimbursement as payment in full for services provided. To strengthen this right, the SMS Office of Legal Services offers the following pre-service agreement options to be signed and dated by the patient that can be used by a physician or clinic:

"I understand that my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts with the exception of Worker's Compensation injuries, Medical Assistance, Medicare or other fully sponsored government accounts. By signing this statement, I revoke all previous agreements to the contrary," or, "I assign to (name of clinic or office) any hospital, medical, surgical, and mental health benefits that I am entitled to under terms of my health care coverage, and agree to be responsible for services not paid, in whole or in part, by my health care payor."

The SMS recently revised the patient information brochure, "Putting the UCR Fee Puzzle Together," that explains the relationship between physicians, patients and health insurance carriers. To order, please contact Maria Springer at 1-800-362-9080 or (608) 257-6781. If you have any questions regarding this balance billing issue, or would like more information, please contact Sally Wencel or Mark Adams of the SMS Office of Legal Services at the number listed above.❑

Wisconsin - Fox River Valley. Established nine-physician two-hospital group with 15 years longevity seeks BP/BC emergency physician to fill 10th position. The candidate will be offered a starting package of $165,000 with corporate membership in two years guaranteeing a $200,000 package. Benefit part of package includes 15% retirement, paid malpractice, health, dental, disability, and $4,000 per year CME. ED volume 27,000 per year, average shift 6 days/6 nights per month, 12 hours per day, double coverage with physician assistants. Interested candidates may apply in confidence to Fred W. Knoch, III, MD, FACEP, 445 Kittiver Court, Neenah, WI 54956;414-725-4639. p7-9/91

Full-time or part-time physician needed for women's health center. Salary negotiable. Partnership a possibility. If interested please forward a current CV to: Aleksander Jakubowski, MD, 5825 W. Capital, Milwaukee, Wisconsin 53216. p7-9/91

Residency position. Wanted, ASAP, "A one-year AMA approved family practice residency program" position to begin as soon after July 15, 1991, as possible. Please contact. Pierre E. Slightam, MD, PO Box 98, Wrightstown, WI 54180 or 414-337-6327. p7/91

Milwaukee area internist seeks BC/BE partner to assume retiring physician's practice. Outstanding opportunity for the right individual to take over an excellent practice in suburban Milwaukee. Available 1992. Please respond ASAP to: Douglas Lillie, MD, 8501 West Lincoln Ave, West Allis, WI 53227; 414-543-4500. p7/91

Outstanding practice potential awaits a medical oncologist willing to assume a busy practice in service area of 200,000. A 344-bed acute care hospital with experienced oncology unit and staff will sponsor practice option of solo or affiliation with others. Located in medium sized midwestern city with family-oriented community and year round recreation. Community is within 60 minutes of Minneapolis. Income guarantee with other benefits. Why wait? Send CV or call: Jackie Parisot, Gielow/Laske Associates, Inc, 306 North Milwaukee St, Milwaukee, WI 53202, 1-800-969-7715; FAX: 414-226-4131. 7/91

Internal medicine The Racine Medical Clinic a 42-physician multi specialty group conveniently located between Chicago and Milwaukee. Well-equipped all new clinic offering salary guarantee with incentive bonus, excellent fringe benefits and early ownership. Please send current curriculum vitae to: RD Lacock, Administrator, Racine Medical Clinic, 3807 Spring St, Racine, WI 53405 7tfn/91

Internal medicine. A prime internal medicine practice awaits you in sunny, metropolitan Phoenix, Arizona. We have additional IM opportunities in picturesque Wisconsin and Ohio. Competitive income guarantee. Available benefits include malpractice insurance, CME allowance, relocation expenses assistance, administrative/financial support and more. For confidential inquiry, call 1 800-969-7715. Dan Jones, Gielow/Laske Associates, 306 N. Milwaukee Street, Milwaukee, WI 53202 7/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 7-9/91

Milwaukee, solo, internal medicine practice, for sale! Retiring internist, creates opportunity to "walk into" established practice and excellent support staff. Adjacent to West Allis Memorial Hospital; expansion began for new, professional/out-patient facility. Added value from hospital's referral program, quality reputation, and community atmosphere. Send CV or call: Dale Wiza, NL/P, Ltd, 1343 Martha Washington Dr, Wauwatosa, WI 53213; 414-453-8999, 1-800-966-8999. 7-8/91

Several opportunities available in this state for radiologists. Solo or group practices available. Potential to earn 1/4 million dollars in first year. All offers include: guaranteed net income; malpractice insurance; paid vacation and CME time, and other inducements and benefits. Please send or FAX CV in confidence to Jackie Parisot, Gielow/Laske Associates, 306 N. Milwaukee St, Milwaukee, WI 53202 or call 1-800-969-7715. FAX: 1-414-226-4131. 7/91

Wisconsin family practitioner and internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to: Stuart Lancer, MD, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 6-9/91

Door County, Wisconsin. One to two BC/BE internists to join hospital-based physicians' clinic. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Gerald M. Worrick, Administrator, 330 South 16th Place, Sturgeon Bay, WI 54235. p6-8/91

Seventeen-physician multi-specialty group needs FP, IM, OB/GYN and Peds. Located on the edge of the Ozarks only one hour from St Louis. Excellent community to raise a family. Excellent school systems and a service area of 200,000 residents. Excellent benefits. Contact Ronald Stevens, Administrator, Medical Arts Clinic, 301 West Liberty St, Farmington, MO 63640; ph 314-756-6751. 6-8/91

Wisconsin. Two young BC internists are seeking a third BC/BE internist for well-established, rapidly growing practice located in pleasant central Wisconsin University town of 30,000. Ideal practice opportunity with equal balance of consultative and primary care; well equipped 120-bed hospital, 12-bed ICU. Comprehensive benefit package includes first year salary guarantee, full malpractice insurance and partnership buy-in after one year. Send CV to: Stevens Point Internal Medicine, SC, 3504 E Maria Dr, Stevens Point, WI 54481. p6-9/91

Family practice Minnesota. Physician needed for broad based practice in exceptional rural community. Shared call, fully equipped and staffed office, outstanding hospital, excellent guaranteed compensation, full benefits, and bonus. **Family practice Wisconsin.** Multi-specialty group of 16 physicians seeks BE/BC physician for partnership. Less than one hour from metro area. For this and other opportunities in the upper midwest, send CV to Mary Jo Cordes, MDsearch, PO Box 21507, St Paul, MN 55121 or call 612-454-7291. 6-9/91

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Physicians Exchange

Continued

Urgent care. Marshfield Clinic is seeking physicians trained and certified in primary care (family practice, internal medicine, pediatrics or emergency medicine) to join newly developing urgent care practice in Marshfield, Wisconsin. Specialists representing all branches of medicine and surgery provide support care and services. A full-time physician will work 45 to 50 hours per week, usually four 12 hour days, including periodic week-ends and holidays. Opportunities exist to combine this practice with an ER practice if desired. Marshfield was recently designated by American Demographics as one of the best small cities in the midwest and America. Wisconsin offers a wonderful four season recreation-oriented lifestyle and this position with fixed hours will afford the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you would like to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director, Physician Staffing, 1000 North Oak Ave, Marshfield, WI 54449, or call, 1-800-826-2345, extension 5376. 5-8/91

BC/BE obstetrician/gynecologist-Door County, Wisconsin. Live in Door County year around. BC/BE OB/GYN to join established BC/GYN in hospital-based practice. Complete facilities available. New LDRP birthing center in modern, progressive 89-bed community hospital. Competitive guaranteed salary, incentive package, malpractice insurance. Attractive benefits. Door County offers exceptional four seasons recreation along Lake Michigan shores, proximity to Milwaukee and Chicago. Top-rated schools. Quality community life for family. Send CV to: Richard C. Murray, MD, 330 South 16th Place, Sturgeon Bay, WI 54235. p5-7/91

Family practice or internal medicine. Riverview Clinic, a 60-member multi-specialty facility has a position available at our regional clinic in Delavan. No night calls or hospitalization responsibility. Excellent lifestyle and benefits in beautiful southern Wisconsin. Send CV to Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 5-7/91

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Baraboo, Wisconsin. Seeking internist, family practitioner, general surgeon and emergency department physician. Growing practices require additional physicians in a beautiful, growing rural community. Contact Thomas Warwick, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608-356-1400. 5-10/91

Emergency medicine. Emergency department director and staff positions are available at several client hospitals in Wisconsin and Michigan. Communities include Watertown and Chippewa Falls, Wisconsin, and Ironwood, Michigan. ED volumes range from low to moderate. Flexible scheduling with 24-hour shifts available. Competitive fees, allowance for professional dues and CME, assistance with relocation expenses are made available to Spectrum independent contract physicians. Director also offered benefit package and annual administrative stipend. For specific details, contact Mallarry Dierkes, Spectrum Emergency Care, PO Box 27352, St Louis, MO 63141; 1-800-325-3982, extension 1029. 5-7/91

Community of 2,000, 50 miles NE of Minneapolis/St Paul, seeks additional family practitioner. Located on the St Croix River and Minnesota border. Practice consists of 13 family practitioners, 2 internists, 2 general surgeons and 1 orthopaedic surgeon. Many specialists

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STUDENT HEALTH CENTER DIRECTOR

UWM

University of Wisconsin-Milwaukee. The Department of Student Health seeks a full-time director/physician to provide patient care and oversee the operation of its comprehensive medical (including sports medicine), psychological, dental, and health promotion services. The department has excellent facilities, occupying 15,000 sq ft on all three floors of its own building. The professional staff includes five full-time physicians (plus four part-time) and 22 additional health professionals. The budget is $1.7 million. With a student enrollment of 25,000, the University of Wisconsin-Milwaukee occupies 90 acres in a lovely residential area on the city's northeast side, one mile from Lake Michigan. **Qualifications.** MD degree and five years experience beyond residency required. Other requirements include residency in an area relevant to college student health and licensure or eligibility for licensure to practice medicine in the state of Wisconsin. Board certification in a medical specialty related to student health needs desired (*eg* gynecology, sports medicine, internal medicine, family practice.) **Application procedures.** Send letter of application, resume, name, address, and phone number for three (3) professional references, and copies of current licenses and board certifications to: Dean Carmen Witt, Chair, Search and Screen Committee, Office of the Dean of Students, University of Wisconsin-Milwaukee, PO Box 413, Milwaukee, Wisconsin 53201. The review of applications will begin on August 1, 1991, and will continue until the position is filled. Selection of a candidate will occur no later than December 1, 1991. The University of Wisconsin-Milwaukee is an Equal Opportunity/Affirmative Action Employer. 7/91

Rice Clinic Medical Center

Central Wisconsin. The Rice Clinic, a 29-physician multi-specialty group is seeking BC/BE individuals in the following specialties: family practice, internal medicine, neurology, psychiatry, general surgery, nephrology, oncology, and rheumatology. Attractive income and ownership arrangements. Excellent practice environment with many outdoor recreational and cultural amenities. Send CV to: Paul R. Ford, Administrator, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481 or call collect: 715-344-4120. 7-9/91

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Physicians Exchange

Continued

available on a part-time basis. Attached to a 90-bed hospital with comprehensive services available. Very stable medical group with pleasant working conditions in a continuous growth mode. Guaranteed first year salary with second year partnership. Fringes include excellent retirement package and car. Contact Lenny Libis, administrator at 715-483-3221. 4-9/91

Family practice, Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multi-specialty groups of thirty-five. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest, family-oriented location offering exceptional four season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in those communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449 or call 1-800-826-2345, extention 5376. 4-7/91

General surgeon, Amery, Wisconsin. Apple River Hospital and Family Medical Clinic have an excellent opportunity available for a general surgeon to join nine-family physicians and an internist in a well-established, progressive group. Come fish, ski, and swim in beautiful Amery; the community is graced with three lakes and the famous Apple River, all located within the city limits! This opportunity is able to offer the best of both worlds: a challenging practice combined with a quality of life your entire family will appreciate. Contact: Loriese A. Stoll, Ramsey Clinic, 640 Jackson Street, St Paul, Minnesota 55101; ph 612-221-3067. 7-9/91

General internal medicine, Marshfield Clinic, 350-physician multi-specialty group practice, is seeking BE/BC family practitioners to join expanding regional centers. Positions are available in west central, northwestern, and north central Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers, and streams. All are ideally suited for physicians seeking to combine professional excellence in a midwest family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700, with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

General surgeon to join a progressive 12-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 4tfn/91

Emergency medicine, Marshfield Clinic-Lakeland Center, located in the beautiful Lakeland area of northern Wisconsin, is seeking an ER physician. This individual must be BE/BC in FP, IM, or EM. This opportunity offers a challenging variety of patients, within a multi-specialty group representing thirteen specialties available for back-up. The Lakeland area offers a unique recreation oriented lifestyle and this position with a 48 hour work week will afford you the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you want to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 4-7/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Internist needed to join one of the leading internal medicine practices in Kenosha, Wisconsin. This is an opportunity to build a strong and vibrant practice within the first one to two years. Office conveniently located on the hospital campus. Kenosha provides an excellent quality of life: many choice yet affordable places to live, superior schools, proximity to recreational facilities, and central location less than one hour from either Chicago or Milwaukee. Compensation competitive including an incentive plan which provides enhanced earning potential. Contact Jan Channon (708) 945-7717 or send CV to 1855 Deerfield Road, Suite 2300, Highland Park, IL 60035. 7-9/91

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Physicians Exchange

Continued

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151 3tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary incentive bonus, plus paid health, life, malpractice, 401K. Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

Urologist. Beautiful southern Wisconsin. BC/BE urologist to join 60-member multi-specialty clinic adjacent to 250-bed hospital. Community of 55,000 with excellent lifestyle. Good benefits and salary guarantee with full partnership after one year. Send CV to: Stan Gruhn, MD, Riverview Clinic, 580 N. Washington St., Janesville, WI 53545. p2-7/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

Medical Meetings-Continuing Medical Education

September 20-21, 1991: "Issues in Primary Care," at Landmark Inn Resort, Egg Harbor. For more information contact: Nadine Punke, Office of Medical Education, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449; ph 715-387-5207. 6-8/91

September 20-21, 1991: American College of Surgeons - Cancer Management Course, at Department of Surgery, Mayo Clinic, Siebens Medical Education Building, Mayo Clinic, Rochester,Minn. Info: Dr John Donohue or Dr David Nagorney, Mayo Clinic, Department of Surgery, Rochester, MN 55905; ph 507-284-2644 or to register, Ms Clifola Coleman, Cancer Management Course, American College of Surgeons, 55 East Erie St, Chicago, IL 60611-2797; ph 312-664-4050. p5-7/91

September 25-27, 1991: "The treatment of panic disorder," at the Masur Auditorium, The Warren Grant Magnuson Clinical Center, NIH, Bethesda, Md. Info: Conference Registrar, Prospect Associates, 1801 Rockville Pike, #500, Rockville Md 20852; ph 301-468-6338. g6-8/91

September 26-28, 1991: (Session I) & October 3-5, 1991 (Session II): Fourth Annual Update in Primary Care, at Landmark Resort, Egg Harbor. Sponsored by Medical College of Wisconsin, Division of General Internal Medicine. For more information, contact: Colleen Berg, 414-257-6040. 7-8/91

October 10-13, 1991; American Society of Internal Medicine 35th Annual Meeting at J.W. Marriott Hotel, Washington, DC. Category 1 CME credit will be available. Info: Lisa Derby at 202-289-1700, ext 615. g6-9/91

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

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December 8-11, 1991: Interim House of Delegates, Las Vegas.
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December 6-9, 1992: Interim House of Delegates, Nashville.

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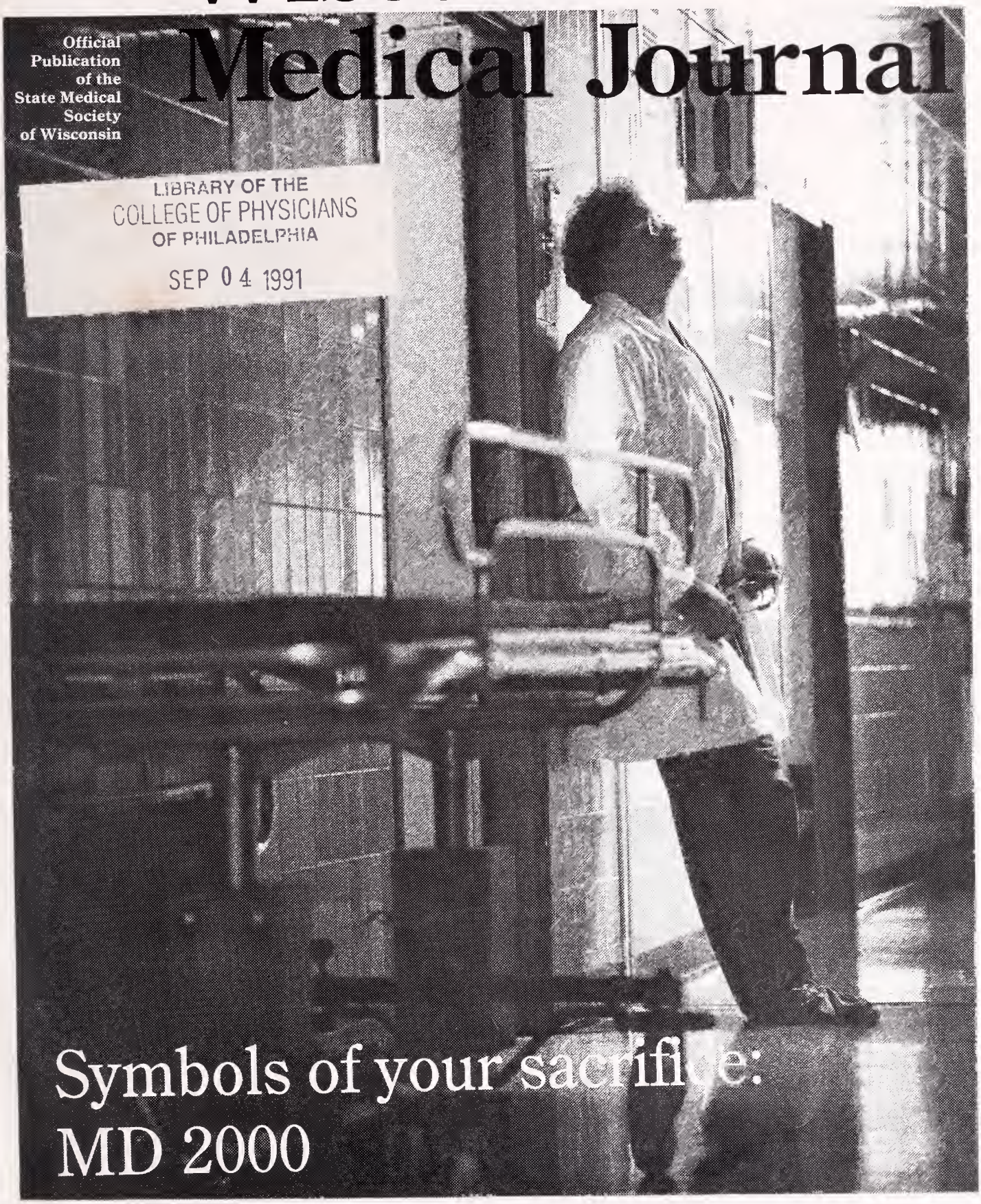

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Contents

August 1991 Vol. 90 No. 8

Opinions

455 *President's page*
'Medicina nusquam non est" (The media's portrayal of "Medicine is universal"): III
by Cyril M. "Kim" Hetsko, MD, Madison
456 *Secretary's report*
Dawn breaks over the AMA
by Thomas L. Adams, CAE, Madison
Editorials
458 Where we have been
by Richard D. Sautter, MD, Marshfield
Letters
459 Delta hospitals need aid
by Victor S. Falk, MD, Stoughton
461 Tyranny is upon us
by James P. Fogarty, MD, Barron

Scientific

463 Recurrence of ^{131}I-induced thyroid storm after discontinuing glucocorticoid therapy
by Anton I. Kidess, MBBS; Robert H. Caplan, MD; Richard H. Reynerston, MD; and Gary Wickus, PhD, La Crosse
465 Pyomyositis secondary to Group A beta hemolytic streptococcus
Michael J. Unger, MD; Gregory N. Van Winkle, MD; and Sherry Ness-Wenum, MD, Menomonee Falls
468 Effect of a sensitive thyrotropin-stimulating hormone assay on dosing of L-thyroxine
by Paul Drinka, MD; Gerald Schomisch, RPh; Clifford Depka, RPh; Richard Deterville, RPh; Donald Nickel, RPh; and Susan Voeks, PhD, King
469 Topical diphenhydramine toxicity
by David T. Bernhardt, MD, Madison

Socioeconomic

473 The Wisconsin Area Health Education Center System
by Charles E. Gessert, MD; Murray L. Katcher, MD, PhD; Ruth Cohen, PhD; David A. Kindig, MD, PhD; Phyllis B. Kritek, RN, PhD; Charles C. Lobeck, MD; Fredric Moskol; and Carol Schramm, Madison and Milwaukee
478 News notes
479 *Public health*
Malignant mesothelioma in Wisconsin, 1959-1989
by Henry A. Anderson, MD; Lawrence Hanrahan, MS; and Jerri Linn Phillips, MA, Madison
482 HMO Financial reports

Organizational

485 MD 2000: Wisconsin doctor selected as national symbol of physicians' sacrifices
by Susan F. Bautch, AMA-WI project coordinator
488 Physician briefs
488 County society news
489 Physicians heed RBRVS call to action; members of Congress express concern
490 SMS president speaks out against AIDS hysteria
491 Obituaries
491 CES Foundation report

Our cover: Kevin J. Fullin, MD, of Kenosha, won a 1991 SMS Physician-Citizen of the Year award and national recognition from the AMA for his community service. See page 485.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

'Medicina nusquam non est'

(The media's portayal of "Medicine is universal"): III

In the last 6 weeks, I have been kept busy putting out fires of hysteria ignited by public ignorance and fear of AIDS and HIV. The fires have had plenty of fuel:

- the death of a Wisconsin pediatrician from AIDS;
- the national news coverage of a Wisconsin surgeon's announcement that he is infected by HIV;
- the discussion at the AMA annual meeting regarding HIV testing for health care workers
- the issuing of CDC guidelines for health care workers at risk for HIV infection; and
- passage by the US Senate of criminal penalties for health care workers who are HIV infected and continue to see patients.

The call for mandatory HIV testing and disclosure for all health care workers has been swift and loud. Empty barrels making the loudest noise, it comes as no surprise that the call for mandatory testing is without basis in reality. There has been *no* proven transmission of HIV from a physician or nurse to a patient. In fact, a number of studies of the patients of HIV-infected physicians and surgeons have found no evidence of transmission. The only suggestion of a possible transmission from a health care worker to a patient involved an HIV-infected dentist in Florida who may have infected five of his patients. Patients are far more likely to be killed by a bolt of lightening than to be infected with HIV by their health care providers. (The same cannot necessarily be said of the risk *to* health care workers *from* patients; 45 health care workers have been infected while caring for others.)

What the public, the news media, the Congress, and even the president seem to have forgotten, or overlooked, is that HIV is not transmitted by casual contact.

Even if we decide that such minuscule risk warrants the expense of testing health care workers, the test results may be meaningless–or worse, misleading–to patients. Because a positive result may not show up in a test for 3 to 6 months after the start of the infection, a health care worker's negative test result may not mean he or she is not HIV-infected. Less informed patients may be given a false sense of security by such tests. Not even those calling for mandatory testing of health care workers desire false assurances.

We physicians have a special set of obligations that find their roots in the Hippocratic Oath and we occupy a special place in society because we are admitted into the most intimate part of people's physical and emotional lives. In my inaugural speech, I challenged physicians to renew their commitment and to continue combining the best of science and the best of compassion, and the current AIDS hysteria has given us the opportunity to meet that challenge. We are in the best position to educate our patients we are in the best position to extinguish the hysteria. And if we don't do it, who will?❑

Cyril M. "Kim" Hetsko, MD

Secretary's report

Dawn breaks over the AMA

I HAVE OFTEN THOUGHT that you can tell something about a person's character by how they emerge from a time of trouble. I am beginning to think the same may be true for a professional association. The 1980s were a turbulent era for the American Medical Association, but the organization has emerged from the crucible renewed.

The AMA has a new vigor, a new vision, and a new set of values. None of this is new for physicians, but the AMA has overcome one of its strongest criticisms: that it was a gang of good ol' boys who were out of touch with the profession. By listening to America's physicians, the AMA has gained a new start. That says good things about the AMA, true; but it says even better things about the men and women who practice medicine. Thanks to the strength of character among America's physicians, a new dawn has come to the AMA.

The new AMA's mission is to help all doctors be better doctors. Not richer. Not more powerful. Not more authoritative. Just better doctors. The tools the new AMA is sharpening for this task are professionalism, patient advocacy, and personal sacrifice. If those tools don't seem very new to you, it is because Wisconsin's physicians have been using them in their daily lives and practices for a very long time (see *Secretary's report:* The secret so few have heard. *Wis Med J* 1991;90(4):150, 152.). But your national association is now of a kindred spirit and giving a larger voice to your values.

What you see now is a more open, more responsive, and less confrontational AMA. What you see now is an AMA that is embracing its own evolution, not resisting it. The entrenched, reactive, hang-on-to-yesterday-at-all-costs AMA is becoming the positive, forward-thinking, pro-active AMA. And proud of it.

Dr James Todd, the AMA's new executive vice president, has been instrumental in leading this change. In his view, the AMA must prove in word and in deed that it is a physician's organization working for the same ends as its member: the good of their patients. Not a political pressure group seeking only to line its members' pockets, and not a self-serving organization seeking only to perpetuate its own existence or increase its own prestige. Every action, every position, every policy of the new AMA will be forced to pass the litmus test of beneficence toward patients.

The AMA's promotion of professionalism boils down to helping doctors help sick and injured people by preserving the patient-physician relationship (another theme that is not new to Wisconsin's physicians). The AMA is as dedicated to fostering competence, compassion and moral accountability within medicine as it is to fighting the forces outside of medicine that would turn the profession into a mere trade, a dispassionate business venture, or an impersonal public utility.

We see this dedication manifested in the AMA's Health Access America plan, designed to address the problems of our uninsured citizens. We see it in *JAMA*'s recent special issue on access to health care, which demonstrated that the AMA is not afraid to wade into a controversy when it is the right thing to do. And we see it in the AMA's new "Member Driven: 2000" theme, the launching of which highlighted the heroic works of physicians around the country. One of those physicians was our own Kevin Fullin, MD, of Kenosha, who graces the *WMJ*'s cover this month. You can read more about Dr Fullin and the AMA program on page 485 of this issue.

Thomas L. Adams, CAE

Is the new AMA the embodiment of organizational perfection? No. It is a creation of fallible human beings, and it will occasionally reflect human weaknesses. But by the same token, it will reflect what is best about you as men and women, and as physicians. The AMA has selected a new path for its future and–while we should not expect that path to be without its bumps, pits, forks and sharp turns–I am confident that it is the correct path and will lead the organization and the profession to greater fulfillment of their potentials.❑

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Editorials
Where we have been

Fifty years ago

Another time of war. The SMS House of Delegates adopted a resolution which read, in part: "...as members of the State Medical Society of Wisconsin in a spirit of patriotic duty, here and now give to each colleague who may be conscripted or who may volunteer, our solemn assurance that we will do everything within our power to protect his practice and preserve it for him during his absence from the community..."

Industrial production was so important to the war effort that the *WMJ* ran a year-long series entitled "Keep the Worker on the Job." Wisconsin actually had the nation's lowest rate of working days missed.

Saving sunshine. Physicians were being asked to help convince rural residents that a new concept called "daylight savings time" would not harm their farming. The time change was touted as way of relieving the stress of the urban industrial worker by providing 25% to 33% more daylight for recreation.

Medicine changes with the times. Scientific booth No. 104 at the SMS annual meeting concerned itself with treating "wringer injury." Children seemed particularly prone to this laundry-room injury, which often required skin grafts and sometimes resulted in death.

Performing an abortion was second degree manslaughter, except when deemed necessary to save the life of the woman. Merely advising a woman on "producing a miscarriage" was punishable by 6 to 12 months in the county jail, a fine of $250 to $500, or both.

Seventy-five years ago

An awakening for public health. An "important observation" was made that surface waters used for disposing of sewage were contaminated by "living tubercle bacilli." The *WMJ* reported that "This is of vital interest not only to cities like Milwaukee, the inhabitants of which drink diluted sewage, but to small communities of a few families who live along a stream and obtain their water from it as it flows innocently by. The imagination need not run riot in an attempt to picture the dangers...."

"We are informed that at Hartford, Conn, there has been inaugurated a research foundation in connection with alcoholism.... There is probably no subject about which more trash has been published and more misinformation circulated than that of the effects of alcohol on the human subject.... (I)t is next to impossible to find real authoritative statements on the use of alcohol in health and disease."

"Who does not remember ... (when) we had to brush off the flies before we could tell what food was before us(?) How we never took any thought ... our only concern being that we did not swallow one of the pesky critters which lingered too long on the portion we were conveying to our mouth."

When health insurance was but a dream. From the *WMJ*: "Industrial insurance is here on a working basis. The idea when first broached was considered socialistic and revolutionary.... Let no one say health insurance is impossible. We live in an age of miracles."

The death rate for American wage earners was twice the rate for "professional men."

A bill was introduced in Congress to make health insurance universal and obligatory among manual laborers. The cost was to be borne two fifths by the employee, two fifths by the employer, and one fifth by the state.

Richard D. Sautter, MD

Some problems have a history. Estimated use of cocaine in the United States was 120,000 *ounces* annually; importation of opium was 450,000 *pounds*; and the number of "drug habitues" was 150,000.

One hundred years ago

SMS annual meeting. A great debate was undertaken as to whether the annual meeting should include a banquet or be devoted entirely to the reading of scientific papers. One physician noted that the members of the Massachusetts Medical Society enjoyed closer social relations because of such a dinner. Another objected: "We can never get up so great a pageant as they do in Boston. We are the Wild Wooly West."

The liability legacy. One of the featured papers at the SMS annual meeting was on avoiding malpractice litigation. The author prefaced his paper with the opinion that "every

action for damages under the head of malpractice is, in a measure, unjust, in its effect upon the community pernicious, and in its effect upon the profession crippling." The advice for avoiding litigation was: 1) know your medicine, 2) take good notes, 3) have a witness present for high-risk procedures, 3) discuss with your patients the "reasonable possibilities of disaster and the minimum ultimate success which may be expected," and 4) avoid even the hint of criticism for another physician.

The germ fiends. The germ theory was a matter of great debate and, at the SMS annual meeting, some derision: "From the array of germs that the germ fiends are now bringing before the unfortunate profession, one would be led to believe that the creator, if there was a distinct creation instead of an evolution, created first various animals and then made a certain number of germs which were inimical to them."

A mayoral welcome. The mayor of Milwaukee gave a speech, welcoming the members of the SMS to his city. He must have been known for either his sense of humor or his courage: "I know most everything about doctoring because I have taken all the medical journals (and) read all the recipes I have seen in the paper for curing disease, and I have tried every recipe I have ever read of. I suppose I have cured more colds and more paralyses by different treatment than any man in the world. I have beaten doctors out of more money than any man in the country.... If it seems to be necessary for you to do any dissecting while you are here I will gladly furnish you a Republican editor, and I should be real glad to have you do something in that way... Again, I welcome you to Milwaukee, and hope you may like the city well enough to advise your wealthy patients to come here to live."

Some things never really change.

–Richard D. Sautter, MD
medical editor❑

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Letters

Delta hospitals need aid

TO THE EDITOR: Through the good offices of the US Committee for Scientific Cooperation with Vietnam, I was recently able to return to the Mekong Delta of Vietnam.

At Can Tho, I visited a medical school established in 1979. There were 600 students in a 6-year program. I also visited two hospitals where I had worked 25 years ago. There were 650 beds in the Can Tho Hospital and much of the building was 95 years old. There were 650 staff, including physicians, nurses, and all other types of help. The total annual budget for that hospital was $200,000 a year. The medical director was paid slightly less than $10 a month.

I visited another hospital of 450 beds farther down in the delta. There, I had a wonderfully warm reception from old friends and new. The staffs were so dedicated and were providing remarkably good care with what facilities they had. They need absolutely everything. Consequently, I am trying to procure used but still useful surgical instruments, medical supplies, and textbooks for these hospitals. If any of you have such equipment, I will be glad to collect it and transport it to Vietnam. I can assure you that it will be gratefully received.

–Victor S. Falk, MD
Stoughton

Editor's note: Donors can reach Dr Falk at 2164 Colladay Point Dr, Stoughton, WI 53589.❑

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Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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References
1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774.

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Additional information available to the profession on request.

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Tyranny is upon us

To the editor: Tyranny, like the experiment in which the frog is slowly cooked by raising the temperature of the water around him in a subtle manner, can be applied to what is happening in medicine today. In my 15 years of practice, I have seen the evolution of dangerous changes. It began with the increased involvement of government in medicine and continued with the rise of cost containment disguised as quality assurance.

My personal experience with the WIPRO program, both on the level of an active member of a hospital medical staff and as an individual, has slowly evolved from a system in which containment of cost was brought about by rules and regulations mandated from a central source. These regulations were often conflicting and initially annoying, but they have since become a major activity of our daily practice.

The new involvement of WIPRO with quality of medicine has further pulled us into the spiraling of a tyrannical system. We are now being investigated and informed of quality assurance issues that often times have little to do with the quality of care of the patient, but rather a means of finding something wrong with the patient's chart.

Medicine is rapidly become a system of irrational rules and regulations whose primary purpose is to save money in the medical budget. It has become a science that is being replaced not by reasoning but by mandate.

Medicine has become a profession in which judgement of our quality of care is decided by a physician who we cannot directly consult, by a physician who has no on the spot evaluation of the patient, by a physician who is being paid to find fault with the charts being reviewed.

Tyranny is upon us and it is time to react!

–James P. Fogarty, MD
Barron ❑

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

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- Paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- Limited to 10 pages, typewritten, double-spaced, 1-inch margins
- Illustrations are encouraged, but must be included in the 10-page length limit
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority in all decisions

Criteria:
- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *Applicability:* usefulness of results to private practitioner, academician, researcher
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- *Organization*
- *Clarity of writing*

Deadline: Entries must be received by the *Wisconsin Medical Journal* no later than February 14, 1992: PO Box 1109, Madison, WI 53701

Recurrence of ^{131}I-induced thyroid storm after discontinuing glucocorticoid therapy

Anton I. Kidess, MBBS; Robert H. Caplan, MD; Richard H. Reynertson, MD; and Gary Wickus, PhD, La Crosse

A 19-year-old woman with Graves' disease developed thyroid storm 8 days after radioactive iodine therapy. The clinical manifestations of thyroid storm promptly improved after treatment with large doses of propylthiouracil, potassium iodide, propranolol hydrochloride, and dexamethasone. Four days after discontinuing dexamethasone, the syndrome recurred and was corrected by reinstitution of the glucocorticoid. We conclude that dexamethasone was an important adjunct for treating thyroid storm and was effective mainly by reducing peripheral triiodothyronine production. *Wis Med J* 1991;90(8):463-465.

THYROID STORM is an infrequent but life-threatening complication of hyperthyroidism.[1,2] In addition to supportive measures, recommended treatment regimens include large doses of propylthiouracil (PTU), iodides, and beta-adrenergic-antagonist drugs. Glucocorticoids are also frequently used, but their benefit in the treatment of thyroid storm has recently been challenged.[3] We report here a patient with radioactive ^{131}I-induced thyroid storm who clearly benefitted from dexamethasone therapy.

Case report

A 19-year-old woman with moderately severe Graves' disease was referred to us for treatment of hyperthyroidism. Eight days following treatment with 6 mCi of radioactive ^{131}I, the patient came to the emergency room with extreme anxiety, hyperkinesis, tremulousness, chills, fever, and sweating. Physical examination revealed a severely agitated patient with an oral temperature of 39°C, a pulse rate of 110 beats per minute, a slightly enlarged and exquisitely tender thyroid gland, marked tremor of the hands, and hyperreflexia. The leukocyte count was 10,600 per mm^3 with 81% segmented neutrophils. The serum T_4 concentration was 234 nmol/L (normal range, 70 to 140 nmol/L) and the serum T_3 level was 5.9 nmol/L (normal range, 1.2 to 2.7 nmol/L). The patient's clinical course and results of iodothyronine measurements are displayed in the figure. She was treated orally with propylthiouracil (PTU), 400 mg every 8 hours; a saturated solution of potassium iodide (SSKI), 5 drops every 6 hours; propranolol hydrochloride, 40 mg every 6 hours; and dexamethasone, 2 mg every 6 hours. Intravenous fluids were also administered. There was prompt and dramatic clinical improvement. By the third treatment day, the serum T_3 level fell to normal (2.0 nmol/L) and the serum T_4 concentration decreased slightly (Fig). At this time, the dexamethasone was discontinued. Despite continuing therapy with PTU, SSKI, and propranolol, thyroid storm recurred

Anton I. Kidess, MBBS, Robert H. Caplan, MD, and Richard H. Reynertson, MD, are with the Department of Internal Medicine, and Gary Wickus, PhD, is with the Department of Laboratory Medicine at the Gundersen Clinic and La Crosse Lutheran Hospital in La Crosse. Address reprint requests to: Robert H. Caplan, MD, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601.The preparation of the report was supported by a grant from the Gundersen Foundation. Copyright 1991 by the State Medical Society of Wisconsin.

4 days later. The patient's pulse rate was 112 beats per minute and her oral temperature was 38.4°C. The thyroid gland remained slightly enlarged but now was only mildly tender. She was very hyperkinetic and severely agitated. The leukocyte count was 6,600 per mm^3 with 70% segmented neutrophils. The serum T_3 concentration increased to 4.7 nmol/L in the face of a slight reduction of the serum T_4; reverse triiodothyronine (rT_3) concentration was 0.55 nmol/L (normal range, 0.18 to 0.51 nmol/L). We reinstituted dexamethasone therapy and again the patient became afebrile and the marked agitation promptly improved.

The following day, the T_3 level reverted to normal. The rT_3 level increased to 2.4 nmol/L (Fig). Treatment with PTU, SSKI, and propranolol hydrochloride was continued and the dexamethasone was gradually tapered over 30 days. Two weeks after discontinuing dexamethasone, the patient was well. At that time the iodothyronine levels were as follows: T_4, 175 nmol/L; T_3, 5 nmol/L; and rT_3, 0.42 nmol/L.

Discussion

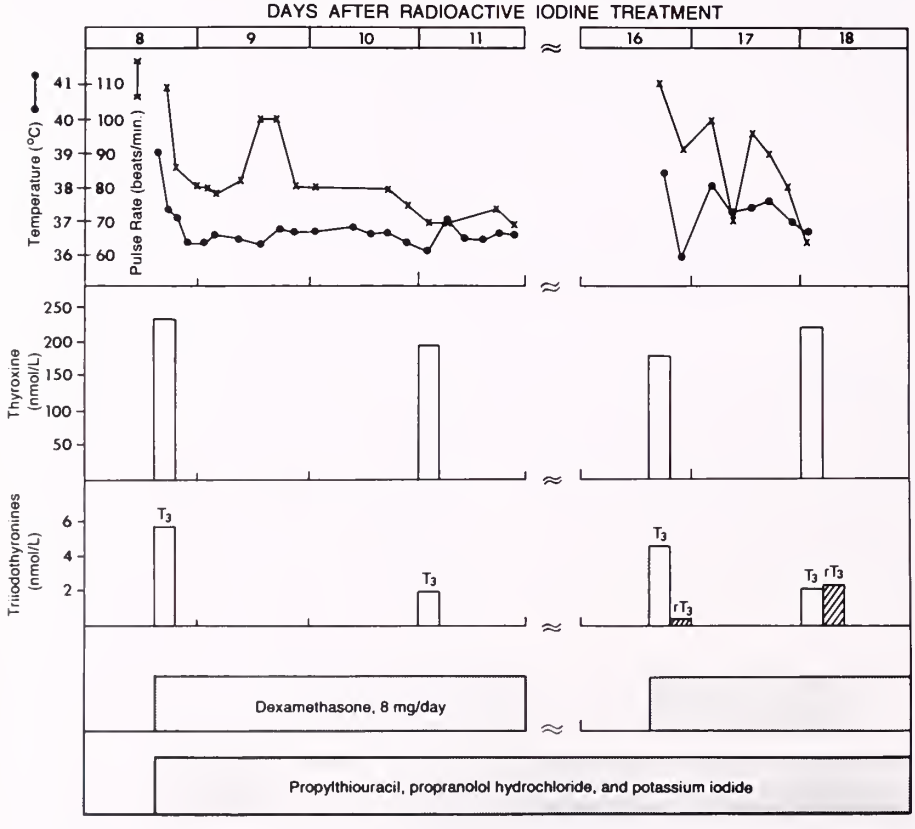
Thyroid storm is a syndrome characterized by exaggerated hyperthyroid manifestations, fever, tachycardia, and prominent symptoms of the central nervous, cardiovascular, and gastrointestinal systems.[1,2] Thyroid storm is a serious disorder with a mortality rate ranging from 10% to 75%.[2] The pathogenesis of ^{131}I-induced thyroid storm remains obscure.[4] The usual explanation has been that ^{131}I causes transient thyroiditis that results in the release of stored T_4 and T_3 into the circulation. The 50% increase in T_3 serum concentration in our patient suggests that an increase in this hormone may have been important in exacerbating her symptoms.

Some patients with ^{131}I-induced thyroid storm on the other hand do not have marked elevation of thyroid hormones.[4] Brooks and Waldstein[5] demonstrated high free T_4 concentrations relative to total serum T_4 values in patients with thyroid storm. These investigators postulated that the events precipitating the thyrotoxic crisis may decrease T_4-binding and sharply increase free T_4 concentration.

Another hypothesis suggests that an increased tissue responsiveness to thyroid hormones, perhaps owing to a change in thyroid hormone receptor sensitivity, is responsible for thyroid storm.[2] Finally, some investigators believe that activation of the autonomic nervous system produces the manifestations of thyroid storm.[2]

For several decades, large doses of glucocorticoids have been administered to patients with thyroid storm.[1,2] Recently, however, contributors to a major endocrinology textbook state that glucocorticoids are seldom indicated.[3] Our patient demonstrated clinical deterioration when dexamethasone was discontinued and prompt improvement when the glucocorticoid was reinstituted. The decrease in temperature and the clinical improvement could have been due to the dexamethasone's effect in reducing radiation thyroiditis. At the time of the second hospitalization, however, the thyroid tenderness had substantially improved and the leukocyte count had reverted to normal. Furthermore, the serum T_4 did not increase as might be expected with continued inflammation and follicular cell destruction. Thus, we believe that the notable clinical improvement associated with a decrease in the serum T_3 level to normal was not due to the anti-inflammatory effect of glucocorticoid therapy.

Williams and coworkers reported a decrease in serum T_4 and T_3 within 24 to 48 hours after the administration of dexamethasone to patients with



Fig–Temperature, pulse rate, and iodothyronine levels during thyroid storm. Note the reduction in serum T_3 (open bars) and increase in rT_3 (shaded bars) concentrations with dexamethasone therapy. The T_4 level did not change substantially. Free T_4 and free T_3 indices paralled the total hormone concentrations.

Graves' disease.[6] The hormone levels returned toward baseline in 5 to 6 days after stopping the steroid. Although these effects were due in part to decreased thyroid gland secretion, reduced peripheral conversion of T_4 to T_3 was the major mechanism for the reduction of T_3. Propranolol hydrochloride, PTU, and dexamethasone all reduce peripheral T_3 production. Croxson and coworkers[7] demonstrated that when PTU and dexamethasone were combined with SSKI, these effects were additive and that the serum T_3 levels could be reduced to normal within 24 hours. The rapid lowering of T_3 and the reciprocal increase in rT_3 in our patient indicates an important role for dexamethasone in reducing peripheral production of T_3. A rapid increase in T_3 levels after stopping glucocorticoid therapy in hyperthyroid patients has been reported.[8]

Although the role of serum levels of thyroid hormones in producing thyroid storm remains unclear, the rapid decrease in serum T_3 concentration in our patient was associated with clinical improvement. Since controlled studies are not likely to be conducted, and since dexamethasone appears to be an important drug for reducing serum T_3 levels, we believe that glucocorticoids should remain a component in the treatment of thyroid storm.

Acknowledgments
The authors thank Ren R. Whitaker, MD, Gundersen-Farrell Clinic of Prairie du Chien, for referring the patient. We also express our appreciation to Kathy Troyanek for preparation of the figure and Kathleen Sandy for expert secretarial assistance.

References

1. Mackin JF, Canary JJ, Pittman CS. Current concepts: Thyroid storm and its management. *N Eng J Med.* 1974;291:1396-1397.
2. Wartofsky L. Thyrotoxic storm. In: Ingbar SH, Braverman LE, eds. 5th Edition. *The Thyroid: A fundamental and clinical text.* Philadelphia, PA: JB Lippincott, 1986:974-981.
3. McKenzie J, Zakarija M. Hyperthyroidism. In: DeGroot LJ, ed. *Endocrinology.* 2nd Edition. Philadelphia, PA: WB Saunders Co, 1989:675.
4. McDermott MT, Kidd GS, Dodson Jr. LE, et al. Radioiodine-induced thyroid storm: Case report and literature review. *Am J Med.* 1983;75:353-359.
5. Brooks MH, Waldstein SS. Free thyroxine concentration in thyroid storm. *Ann Int Med.* 1980;93:694-697.
6. Williams DE, Chopra IJ, Orgiazzi J, et al. Acute effects of corticosteroids on thyroid activity in Graves' disease. *J Clin Endocrinol and Metab.* 1975; 41:354-361.
7. Croxson MS, Hall TD, Nicoloff JT. Combination drug therapy for treatment of hyperthyroid Graves' disease. *J Clin Endocrinol Metab.* 1977;45:623-630.
8. Wimpfheimer C, Stäubli M, Schädelin J, et al. Prednisone in amiodarone-induced thyrotoxicosis. *Brit Med J.* 1982;284:1835-1836.❑

Pyomyositis secondary to Group A beta hemolytic streptococcus

Michael J. Unger, MD; Gregory N. Van Winkle, MD; and Sherry Ness-Wenum, MD, Menomonee Falls

Pyomyositis is a primary bacterial infection of skeletal muscle not formed by local extension from superficial tissues. It is relatively frequently seen in tropical climates but reportedly rarely seen in temperate climates such as North America. In this report, we present a 67-year-old man with a primary Group A beta hemolytic Streptococcal infection of the quadriceps muscle of the left leg. *Wis Med J* 1991;90(8):465-467.

Dr Unger, Dr Van Winkle and Dr Ness-Wenum are with the Community Memorial Hospital in Menomonee Falls. Address reprints to: Michael J. Unger, MD, Community Memorial Hospital, W180 N8085 Town Hall Rd, Menomonee Falls, WI 53052. Copyright 1991 by the State Medical Society of Wisconsin.

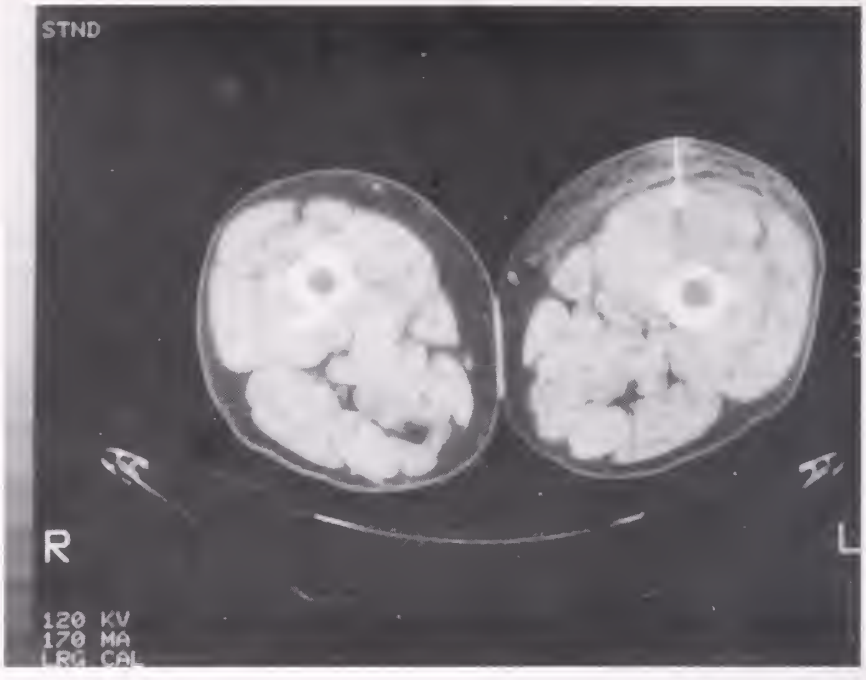
Bacterial pyomyositis, a purulent infection of skeletal muscle, is a common disease of tropical areas but is rarely seen in more temperate climates. Less than 100 cases in the United States have been reported in the literature.[1] The majority of these cases are secondary to Staphylcoccus aureus with only 1% to 5% due to streptococcal infections. In this report, we describe a healthy 67-year-old male with a Group A beta hemolytic streptococcal infection of the left thigh.

Case report

A previously healthy 67-year-old male was admitted to Community Memorial Hospital with fevers of 3-day duration, producing temperatures as high as 103°F, associated with chills and severe left leg pain. No history of trauma or recent travel was obtained.

On admission, his temperature was 101°F. He was obviously uncomfort-

able and diaphoretic, noticeably favoring his left leg when walking. Examination of the left leg revealed generalized swelling of the anterior musculature of the thigh. Exquisite tenderness of the quadriceps muscle was noted, but there was no evidence of redness, trauma or penetrating injury. Leukocytosis was noted with a WBC count of 27,200 with a moderate left shift f 11 bands, 79 segs, 7 monos and 2 lymphs. Hematocrit was 42%. Erythrocyte sedimentation rate was significantly elevated at 85mm per hour. Creatine phosphokinase was normal, as was fasting blood sugar of 100. Plain film of the thigh was essentially normal, however, CT scan showed a 6x5x26 cm area of low attenuation of the anterior musculature of the thigh compatible with a developing abscess (Fig 1).



Fig–CT scan of low area attenuation of the anterior musculature of the thigh compatible with a developing abscess.

Under CT scan guidance, a needle aspiration was done and a small amount of cloudy fluid was obtained. Culture of the aspirated material was positive for Group A beta hemolytic streptococcus (Strep. Pyogenes) sensitive to all antibiotics tested. Therapy was started empirically with cefazolin 1 gm IV 4 times daily, and the patient was taken to the operating room where incision and drainage was performed. No frank abscess was found, although significant muscle edema was noted. Cultures obtained at surgery were also positive for Group A beta hemolytic streptococcus.

He was treated for 10 days with cefazolin with resolution of fever, leukocytosis, and leg pain, and was discharged on a high-dose oral penicillin. The surgical wound healed uneventfully, and the patient made a full recovery without residual problems.

Discussion

Bacterial pyomyositis was first described in the early 20th century in areas such as Africa, Asia and the West Indies. Since that time, pyomyositis remains a common entity in these tropical areas, however, was only first reported in the United States in 1971.[2] Since that time, fewer than 100 cases have been described in the American literature.[1] The most common organism is Staphylcoccus aureus (more than 90% of the cases). Three percent to 5% are secondary to streptococcal species, including hemolytic and nonhemolytic types.[3] Unusual pathogens, including Yersinia Enterocolitica,[4] Klebsiella,[5] and Neisseria gonorrhea[6] have also been reported. Only 22 cases of pyomyositis secondary to Group A beta hemolytic streptococcus have been described the entire world literature.

Pyomyositis progresses in three stages. The invasive stage is characterized by fever, muscle pain and swelling. The affected muscle has an indurated or "woody" texture and is quite tender, but frank pus or abscess formation is not seen. This is followed in hours to days by a suppurative stage characterized by localized abscess formation in the muscle. Eventually, the entire muscle becomes involved by the infectious process with the development in some patients of complications including DIC,[8] metastatic abscesses, sepsis, and rhabdomyolysis.[9] Approximately 90% of patients seek medical care in the suppurative stage, but our case was diagnosed in the late invasive stage. Nearly all are febrile, but positive blood cultures are seen in fewer than 20%.[10] As in our patient, the thigh is the most commonly affected muscle group, with the calf and buttock areas less frequently seen. Involvement of the abdominal musculature can even be present.[11]

Diagnosis is made by isolation of the infecting bacteria from the affected muscle. Aspiration and surgical intervention can be guided by several radiologic techniques principally CT scan as in our case, however, ultrasound and nuclear imaging such as gallium and bone scans have been employed.[12]

As in this patient, most cases are males and otherwise healthy, although cases in patients with diabeties,[13] AIDS[1] and acute leukemia have all been described. Pathogenesis is unclear. For the most part, pyomyositis does not appear to be secondary to local extension from superficial tissues as pre-existing

trauma to the muscle is seen in only a distinct minority of cases.[7] Seeding of muscle secondary to bacteremia has been a consideration, but blood cultures are positive in less than 20% of cases. In addition, in bacteremic states such as endocarditis, musculoskeletal complications, including pyomyositis, are exceedingly rare.[15] Because of predominance in tropical area of the world, factors such as coexisting parasitic infections and nutritional deficiencies have been postulated.[16] Despite multiple observations and numerous hypotheses, no unifying explanation has been conclusive.

References

1. Gaut P, Wong PK, Meyer RD. Pyomyositis in a patient with acquired immunodeficiency syndrome. *Arch Intern Med.* 1988;148(7):1608-1610.
2. Levin MJ, Gardner P, Waldvogel FA. "Tropical" pyomyositis: An unusual infection due to Staphylcoccus aureus. *N Engl J Med.* 1971;284:196-198.
3. Chiedozi LC. Pyomyositis: Review of 205 cases in 112 patients. *Am J Surg.* 1979;137(2):255-259.
4. Brennessel DJ, Robbins N, Hindman S. Pyomyositis caused by Yersinia enterocolitica. *J Clin Microbiol.* 1984;20:293-294.
5. Schwab R, Panwalker AP. Klebsiella pyomyositis. *Am J Med.* 1986;81:1116-1117.
6. Swarts RL, Martinez LA, Robson HC. Gonococcal pyomyositis. *JAMA.* 1981;246:246.
7. Adams EM, Gudmundsson S, Yocum D. Streptococcal Myositis. *Arch Intern Med.* 1985;145:1020-1023.
8. MacLaurin JP. Spontaneous streptococcal myositis associated with disseminated intravascular coagulopathy. *J Am Osteopath Assoc.* 1977;76:675-678.
9. Armstrong JH. Tropical pyomyositis and myoglobinuria. *Arch Intern Med.* 1978;138;1145-1146.
10. Gibson RK, Rosenthal SJ, Lukert BP. Pyomyositis: Increasing recognition in temperate climates. *Am J Med.* 1984;77:768-772.
11. Beck W, Grose C. Pyomyositis presenting as acute abdominal pain. *Pediatr Infect Dis.* 1984;3:445-448.
12. Yousefzadeh DK, Schumann EM, Mulligan GM, et al. The role of imaging modalities in diagnosis and management of pyomyositis. *Skeletal Radiol.* 1982;8:285-289.
13. Brown RL. Pyomyositis in patients with diabetes. *Postgrad Med.* 1989;86:79-89.
14. Blatt J, Reaman G, Pizzo. Pyomyositis in acute lymphocytic leukemia heralded by cutaneous vasculitis. *Med Pediatr Oncol.* 1979;7:237-239.
15. Churchill MA, Geraci JE, Hunder GG. Musculoskeletal manifestations of bacterial endocarditis. *Ann Intern Med.* 1977;87:754-759.
16. Engel D. Tropical pyomyositis: A thiamine deficiency disease. *Med Hypotheses.* 1981;7:345-352.

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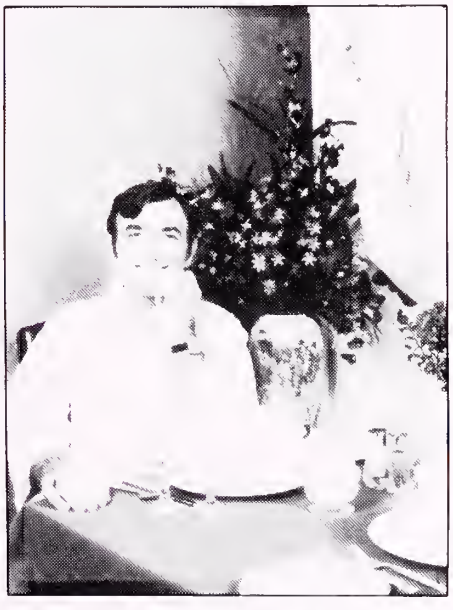

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Effect of a sensitive thyrotropin-stimulating hormone assay on dosing of L-thyroxine

Paul Drinka, MD; Gerald Schomisch, RPh; Clifford Depka, RPh; Richard Deterville, RPh; Donald Nickel, RPh; and Susan Voeks, PhD, King

The Wisconsin Veterans Home has had a special interest in thyroid disease since 1986. Until recently, dosage adjustment of L-thyroxine in residents with primary hypothyroidism was accomplished by individual physicians guided by standard thyroid function tests. A shift to a sensitive thyrotropin-stimulating hormone (TSH) assay provided an opportunity to assess the frequency of sensitive TSH suppression secondary to excessive doses of L-thyroxine which would not be recognized by the standard TSH assay. We reviewed the charts of 46 residents who were not acutely ill and had been in the facility at least 6 months. Sensitive TSH was determined while on a stable dose of L-thyroxine for a minimum of 6 weeks. Six residents (13%) had low sensitive TSH levels indicating an excessive dose of L-thyroxine. The application of the sensitive TSH assay resulted in dose reduction. *Wis Med J* 1991;90(8):468-469.

PRIOR TO THE DEVELOPMENT of sensitive thyrotropin-stimulating hormone (STSH) assays, clinicians had great difficulty determining if a patient on thyroid hormone replacement therapy was being over-treated. An excessive dose of thyroid hormone may lead to increased demand for cardiac output, osteoporosis, glucose intolerance, elevation in certain hepatic enzymes, and possibly increased anxiety.[1-3] In addition, the usual replacement dose of L-thyroxine decreases in the elderly.[4] The institutionalized elderly, therefore, are at risk for iatrogenic hyperthyroidism. The Wisconsin Veterans Home has had a special interest in thyroid disease for the last several years and has screened its residents for hypothyroidism. A number of our residents are being treated with L-thyroxine as replacement therapy. When a STSH assay became available, we determined STSH levels on those residents who had previously had their L-thyroxine dose adjusted without the benefit of a STSH assay.

Dr Drinka is the medical director of the Wisconsin Veterans Home and an associate clinical professor of internal medicine at the University of Wisconsin-Madison. Schomisch, Depka, Deterville, Nickel and Dr Voeks are with the Wisconsin Veterans Home in King. Portions of this paper were presented at the annual meeting of the Gerontological Society of America, Nov 17, 1990, in Boston. Address reprint requests to: Paul Drinka, MD, Wisconsin Veterans Home, King, WI 54946. Copyright 1991 by the State Medical Society of Wisconsin.

Methods

Pharmacy records were reviewed to identify all residents being treated with L-thyroxine. To be included in this study, a resident must have been in the facility for at least 6 months and have been on a stable dose of L-thyroxine for at least 6 weeks. The following criteria were used for exclusion: acute illness, therapy with corticosteroids, as well as exposure to iodine or radiological contrast agents. The methodology of the STSH assay changed during the study. The following kits were used:

Bio-Rad Echoclonal™ hTSH IRMA (lower normal limit 0.30 µIU/mL)

Bio-Rad CoTube™ TSH IRMA (lower normal limit 0.46 µIU/mL)

Throughout the entire period, only Flint Synthroid brand of L-thyroxine was administered. STSH assays were drawn in the fasting state between 6:30 - 8:30 am prior to administration of medication, approximately 24 hours after the last dose of L-thyroxine. Previous investigators who have used a STSH assay to determine proper dose adjustment of L-thyroxine have generally concluded that there is little need for concomitant measurement of circulating levels of thyroid hormone.[5-7] For this reason, T_4 and FTI levels were not routinely determined in these laboratory studies.

Results

We reviewed the charts of 46 residents who were not acutely ill and had been in the facility at least 6 months. STSH was determined while on a stable dose of L-thyroxine for a minimum of 6 weeks. Six residents (13%) had low STSH levels indicating an excessive dose of L-thyroxine (Tables 1 and 2). The application of the STSH assay had a meaningful effect resulting in dose reduction in all six cases. There was also a substantial percentage of residents (46%) whose dose of L-thyroxine was not

Table 1.–Distribution of residents by STSH range.

No.	Status
6 (13%)	excessive dose of L-thyroxine
19 (41%)	therapeutic dose
21 (46%)	inadequate dose

completely adequate to suppress STSH levels into the normal range. This finding, however, would not require the sensitive assay. A follow-up review of the records of individuals with high STSH values found that the physicians subsequently advanced the dose of L-thyroxine in all cases unless there was only minimal STSH elevation.

Discussion

The application of the STSH assay uncovered a substantial proportion of nursing home residents who were being given excessive doses of L-thyroxine. The STSH assay is highly desirable in this fragile nursing home population because they are probably the most likely to suffer complications from excessive doses and the least likely to have such excessive doses diagnosed on clinical grounds.

Table 2.–Characteristics of residents with low STSH.

Subject #	Sex	Age	Weight (lbs)	L-thyroxine Dose	STSH (μIU/ml)
1	M	72	108	0.125 mg	0.30[2]
2	F	80	128	0.100 mg	0.01[2]
3	F	93	133	0.100 mg	0.20[1]
4	F	76	145	0.100 mg	0.20[2]
5	M	65	190	0.200 mg	0.01[2]
6	M	75	159	0.050 mg	0.09[2]

[1]Bio-Rad Echoclonal™ hTSH IRMA, lower normal limit 0.30 μIU/ml.
[2]Bio-Rad CoTube™ TSH IRMA, lower normal limit 0.46 μIU/ml.

References

1. Fallon MD, Perry HM III, Bergfeld M, et al. Exogenous hyperthyroidism with osteoporosis. *Arch Intern Med.* 1983;143:442-444.
2. Beckett GJ, Kellett HA, Gow SM. Raised plasma glutathione S-transferase values in hyperthyroidism and in hypothyroid patients receiving thyroxine replacement: evidence for hepatic damage. *Brit Med J.* 1985;291:427-431.
3. Grund FM, Niewoehner CB. Hyperthyroxinemia in patients receiving thyroid replacement therapy. *Arch Intern Med.* 1989;149:921-924.
4. Rosenbaum RL, Barzel US. Levothyroxine replacement dose for primary hypothyroidism decreases with age. *Ann Int Med.* 1982;96:53-55.
5. Frey H, Johannesen O, Kapelrud H, et al. Appropriate replacement dose of thyroxine in primary hypothyroidism. *Acta Med Scand.* 1987;222:163-167.
6. Watts NB. Use of a sensitive thyrotropin assay for monitoring treatment with Levothyroxine. *Arch Int Med.* 1989;149:309-312.
7. Gow SM, Caldwell G, Toft AD, et al. Relationship between pituitary and other target organ responsiveness in hypothyroid patients receiving thyroxine replacement. *J Clin Endocrinol Metabolism.* 1987;64(2):364-369.❑

Topical diphenhydramine toxicity

David T. Bernhardt, MD, Madison

This paper will review an acute onset of mental confusion associated with hallucinations secondary to vigorous administration of topical Caladryl lotion and Benadryl spray in an 8-year-old boy with chickenpox. The article discusses the toxicity of both oral and topical diphenhydramine use, along with the differentiation of varicella encephalitis from diphenhydramine toxicity. Delirium can be described as an acute clouding of consciousness associated with visual and tactile hallucinations, disorientation, and misperceptions. In a child who is already suffering from an infectious illness, encephalitis must be high on the list of the physician's differential diagnosis. The physician, however, must never overlook ingestions, even from topical, over-the-counter medications. The case described illustrates this point. Although this appears to be the fourth case report on this subject, the diagnosis was partially obscured by the fact that the local pharmacist could not find any documented cases despite a computer search of diphenhydramine toxicity at the time of admission and the report of only one or two cases by the Parke-Davis pharmacist. *Wis Med J* 1991;90(8):469-471.

An 8-year-old boy was admitted to the hospital because of the acute onset of a confused mental state. The boy was previously healthy with known familial exposure to chickenpox and outbreak of a vesicular, pruritic, erythematous rash approximately 4 days prior to admission. His mother had been applying Caladryl lotion (1% diphenhydramine, 2% alcohol, 2% methanol by volume) generously over his entire body every 4 hours almost continuously for 36 hours directly up to the time of admission. Six hours prior to admission, the patient had diphenhydramine topical spray applied in a further attempt to relieve the pruritis. Three

hours later, he received his last application of Caladryl lotion. The mother was persistent in applying the lotion because the patient was unable to sleep and constantly complained of itching. Up to this point, the entire course of his varicella infection had been unremarkable.

Four hours after receiving the topical diphenhydramine, the patient was found wandering around his room, alert and awake but very confused and hallucinating. The hallucinations consisted of waving to neighbors who were not in their yard at 1 am, visualizing dogs at the emergency room entrance, and thinking he was at the store. There was no history of significant trauma, loss of consciousness, or ingestions.

The patient's medical, family, and social histories were unremarkable.

On admission, the patient was alert, cooperative, well-developed, well-nourished, and in no acute distress. He was covered with mainly crusted lesions over his body. Vital signs were all within normal limits. His examination was unremarkable except for the neurological portion. He was alert but unable to follow simple, two-step commands. He was actively hallucinating–seeing both his brother and a cat in the examining room when neither were present. He was oriented to person, but not to either time or place. The remainder of the neurological examination was unremarkable.

All tests, including a complete blood count, electrolytes, chemistry profile, cerebrospinal fluid studies with culture, head CT scan and EEG were normal.

Our impression at that time was that the child's condition was caused by varicella encephalitis rather than a drug ingestion. Diphenhydramine toxicity from topical application was initially considered unlikely as our pharmacist could not find any documented cases, despite a computer search, and the Parke-Davis pharmacist knew of only one or two isolated cases.

A toxin screen was positive for diphenhydramine and acetaminophen. A serum diphenhydramine level was 1.0 µg/mL at the time of admission and was 0.3 µg/mL approximately 15 hours later (therapeutic

Continued on next page

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level = 0.0092 µg/mL, lethal level = 8 µg/mL, and most patients with documented diphenhydramine intoxication have serum level >0.6 µg/mL.

The patient's hospital course after the initial work-up was unremarkable. No further oral or topical diphenhydramine was given. He continued to hallucinate until approximately 12 hours after admission. The patient was observed overnight and was discharged the next day with clear sensorium.

Discussion

This is a clear example of acute delirium in an 8-year-old boy who was initially felt to have encephalitis, probably secondary to varicella. Initial symptoms and signs of varicella encephalitis would appear very similar to the case above, but may also include vomiting and seizures. CSF examination usually shows an increased number of lymphocytes.[1]

A toxic ingestion was initially disregarded because of a lack of information at our pharmacists disposal and later a report of only two cases by the Parke-Davis pharmacist. After a review of the Index Medicus, however, and later a Medline search, this appears to be at least the fourth such case report.[2-4]

Diphenhydramine is an antihistamine with anticholinergic and sedative effects. Benadryl spray blocks the action of the histamine that causes the itch. There is a warning not to use the spray on open skin areas and not to use in chickenpox or measles infection without consulting a physician.[5] The absorption of diphenhydramine through the open pox appears to be quite good, although it has never been documented. Management includes removal of the spray or lotion from the skin and supportive care until the drug is excreted from the body.

When diphenhydramine is given orally or intravenously, frequent side effects at therapeutic levels may include sedation, dizziness, disturbed coordination, epigastric distress, and thickening of the bronchial secretions. Antihistamine overdosage may vary from CNS stimulation to depression. Anticholinergic side-effects may include dry mouth, fixed, dilated pupils, flushed skin, urinary retention and delirium.[6] Oral ingestions are managed with either ipecac-induced vomitting or gastric lavage. Activated charcoal binds antihistamines well and should be administered. The drug is metabolized by the liver and is protein bound. Therefore, attempts at increasing urinary secretion or dialysis will be fruitless.[7]

Delirium and anticholinergic seizures may respond to physostigmine. Physostigmine increases the concentration of acetylcholine at its receptor sites. The side effects of physostigmine, however, may be worse than the antihistamine overdose itself and should be used with caution. These side effects include respiratory collapse, bradycardia, hypotension, atrial arrythmias, asystole and seizures.[7]

Although topical diphenhydramine toxicity seems rare, I feel it may be more common than reported. Patients should be warned about using only Calamine lotion (as opposed to Caladryl) for topical relief from the pruritis from varicella infection. The combination of oral and topical diphenhydramine or topical Caladryl and Benadryl must be avoided as the additive effects of these over-the-counter medications may be quite serious. Finally, this is an excellent lesson in the need to consider all medications, over-the-counter, topical and prescription, in the differential diagnosis of many diseases.

References

1. Moffet HL. Neurologic syndromes. In: *The Pediatric Infectious Diseases*. 3rd ed. Philadelphia, PA: Lippincott;232-237.
2. Woodward GA, Baldassano RN. Topical diphenhydramine toxicity in a 5 year old with varicella. *Pediatric Emergency Care*. 1988;4:18-20.
3. Tomlinson G, Helfaer M, Wiederman BL. Diphenhydramine toxicity mimicking varicella encephalitis. *Pediatr Infect Dis*. 1987;6:220-221.
4. Filloux F. Toxic encephalopathy caused by topically applied diphenhydramine. *J Peds*. 1986;108:1018-1020.
5. PDR for nonprescription drugs. 1991;p 637.
6. PDR for prescription drugs. 1991; p 1623.
7. Mack RB. Antihistamine overdose–throw psychics to the dogs. *Contemporary Pediatrics*. October 1990;7:45-57.❑

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In April 1991, the federal Health Resources and Services Administration announced that it had awarded funding for the first 3 years to the new Wisconsin Area Health Education Center (AHEC) System. Since 1970, more than 30 states have developed AHEC programs, which foster and support long-term partnerships between health professions education campuses and underserved communities. AHEC programs are developed to improve access to health care in underserved areas by changing the way that health care providers are educated. During the past 2 years, Wisconsin has planned and developed an AHEC project. This report reviews the principles that guide AHECs, describes the developing AHEC system in Wisconsin, and offers a view of AHEC's potential long-term role in improving health care in Wisconsin's underserved communities.

Background

The national AHEC program was created in the early 1970s as one of several federal initiatives designed to improve access to care in the nation's underserved communities. The AHEC program was designed to improve the specialty and geographic distribution of health care providers, and was based on a recommendation of the Carnegie Commission on Higher Education's report, *Higher education and the nation's health: Policies for medical and dental education*.[1] This report recommended that federal funds be provided "to support the development of Area Health Education Centers in rural and inner city areas. These centers would be affiliated with university health science centers and would perform all the functions of these centers except for the basic education of MD and DDS candidates. They would be designed to improve the quality of health training in their areas, help to overcome problems of geographical maldistribution of health manpower, encourage training for primary care, and remove the pressure in many communities for the establishment of new medical schools."[2]

In the early 1970s, AHECs were seen primarily as vehicles for improving the geographic distribution of primary care physicians, and it was assumed that they would have their major effect in rural areas. By the mid-1970s, however, the developing national AHEC program had embraced several additional goals. It was recognized that the geographic isolation from health professions education programs of many underserved rural communities was paralleled by the cultural isolation of many underserved urban communities. In this light, the need for urban AHECs was clarified; the characteristics of both rural and urban AHECs are now well recognized.[3] In addition, AHECs recognized that the health care needs of most underserved areas were multidisciplinary in nature and that to meet these needs, educational programs for a range of health care providers (eg, physicians, nurses, physician assistants, physical therapists, and nurse practitioners) were needed. During the later 1970s and through the 1980s, AHECs developed as multidisciplinary and—in some instances–collaborative training efforts.[2]

Federal funds for AHEC, administrated by the Health Resources and Services Administration, are awarded to medical schools. Several built-in characteristics of AHEC, however, serve to assure that these projects develop as true campus and community partnerships, and that AHEC resources are used to support multidisciplinary educational programs in the target communities. A key feature in this regard is the contractual relationship between the campuses and the target communities, in which concerned faculty and community leaders plan and agree upon the programs which the AHEC will

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support. This contractual mechanism serves to assure that campus and community leaders identify their common interests, which serve as the basis for the AHEC programs. Some of the mature AHEC systems, such as the project in North Carolina, established in 1972, have developed the AHEC system as a vehicle for a range of state initiatives designed to improve access to health care and to address specific health care problems within the state.[4]

Successful AHEC programs emphasize bringing together existing leadership, programs, and concerns. AHECs build upon existing commitments within the target communities, and within the participating institutions and faculties. AHECs have neither the resources nor the intention to duplicate, compete with, or displace existing efforts with which the AHEC shares goals. AHECs build upon, empower, and enhance existing efforts in the areas of needs assessment, community planning, data collection and analysis, and decentralized and community-based health professions education. AHECs use a strong, well-developed advisory structure at both the statewide and local levels to maximize the potential for developing good working relationships with existing programs.

Initiation in Wisconsin

Wisconsin has a longstanding reputation for stable, progressive institutions and strong human services programs. Problems with access to health care, however, have accumulated in both the urban and rural areas of the state and, in recent years, have begun to be reflected in deteriorating health indices. During the summer and fall of 1987, the then-president of the State Medical Society, Kenneth M. Viste, Jr, MD, convened a task force on rural education. The task force eventually developed 32 recommendations including recommendation 11: "Establishment of an Area Health Education Center (AHEC) should be pursued." These recommendations were approved by the House of Delegates at their annual meeting in 1988. Shortly after the Medical Society's report was accepted, the Legislative Council created a special committee on Health Care Services, made up of the leadership of the two houses of the Legislature. This committee reviewed the recommendations of the SMS and urged the two medical schools—the University of Wisconsin Medical School in Madison, and the Medical College of Wisconsin, in Milwaukee--to investigate the possibility of developing an AHEC proposal. The two medical schools agreed to plan the AHEC as a joint effort and brought the leadership of the campuses together to launch the new AHEC partnership with a planning agreement completed in May 1990.

Consistent with AHEC's role in building upon and enhancing existing efforts with which it shares common goals, early in the process of developing plans for AHEC in Wisconsin a Statewide Program Advisory Committee (SPAC) was established. In establishing the SPAC, care was taken to assure that representatives were included to balance regional, professional, and community concerns. SPAC brought many voices together into the AHEC planning process. Thus, SPAC and task forces on Rural Health, Nursing, and Minority Recruitment were convened several times during the proposal planning process in the summer and fall of 1990. The planning process served to identify and verify health care needs throughout the state, and to identify some of the existing training resources and agencies, programs, and institutions that would be interested in participating in the AHEC effort.

The planning for the Wisconsin AHEC System has been consultative and has sought the views of campus and community leaders throughout the state. During the proposal development phase, the members of SPAC and its task forces individually reviewed and provided suggestions on portions of the proposal.

The application for federal support for the Wisconsin AHEC System was submitted to the federal Department of Health and Human Services Nov 8, 1990. The federally supported AHEC project is planned for October 1991 through September 1999. It is hoped that state matching funds will enable initiation of planning for AHEC activities in Northern Wisconsin and the inner city of Milwaukee before October 1991.

Wisconsin AHEC Overview

The Wisconsin AHEC system will develop four local AHECs addressing four distinct areas of the state with very different local health care issues and resources:

In northern Wisconsin, the AHEC will serve a 38 county target area that is largely rural and far from many of the major health professions education campuses. In this area of Wisconsin, demand for health care providers far exceeds the rate of influx of new professionals, and some services–such as obstetrics–are being curtailed in existing practices. As a result, critical gaps have appeared in primary health care. These gaps are increasingly apparent in health indices, such as the Native American (almost all in northern Wisconsin AHEC target area) infant mortality rate which is more than twice that for whites, and 70% higher than the Native American infant mortality rate for the United States.

The Milwaukee AHEC will serve Milwaukee County which, despite the superb quality of its health care institutions, has teenage pregnancy and infant mortality rates among the worst in the country. With half the state's AIDS cases, rapidly growing cocaine problems, a dramatic jump in reported child abuse, and many other problems, Milwaukee has urgent inner city health care needs, at a time when the number of inner city providers–both private and public—is dropping

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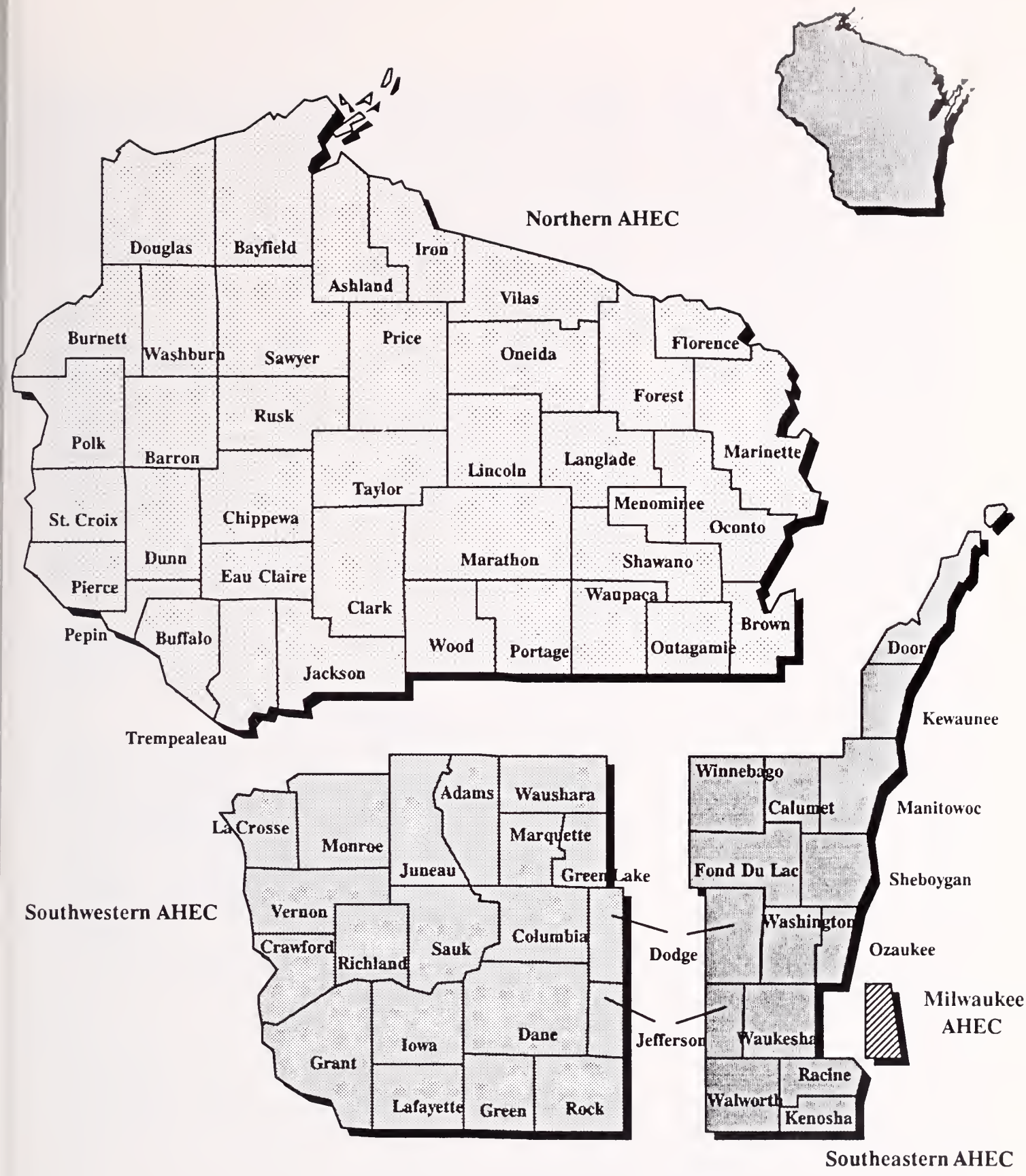

PROPOSED STATEWIDE WISCONSIN

AHEC AREAS

Continued from page 474
annually with few new services being established.

During the third year of the project, an AHEC will be established in southwest Wisconsin, where it will serve 18 largely rural counties. Many communities in this part of Wisconsin are served by small, rural hospitals which are having increasing difficulty in maintaining services because of shortages of nurses, physical therapists, primary care physicians, and a variety of allied health professionals.

In the third year of the project, the AHEC System will also establish an AHEC to serve southeast Wisconsin, where it will serve 15 largely agricultural counties between Lake Michigan and the Fox River Valley. This area of the state is characterized by multiple, small- and medium-sized hospitals, persistent and growing shortages of nurses and allied health personnel (in some communities) and an aging primary care provider population.

Each local AHEC will be incorporated as a freestanding entity, or will be developed under the aegis of an existing corporation, such as a community hospital. The local AHEC corporation will hire a director and establish a local AHEC office, and will be responsible for the completion and quality of its AHEC-supported educational programs.

A local advisory committee will be developed for each center. The majority of the membership of the advisory committee will be drawn from the area served by the center, and will include both health service providers and consumers. The advisory committee will identify, select, and prioritize programs that will be carried out by the AHEC.

Each of the local AHEC offices will be responsible for planning, developing and implementing health professions education programs in its target areas. In planning local programs, the AHECs must consider three major factors in formulating their annual plans:

- local needs for health care providers;
- opportunities for training, as represented by concerned faculty and the clinical facilities of the target area; and
- applicable federal AHEC requirements.

The Wisconsin AHEC System leadership anticipates that initially the new AHECs will focus on developing their new partnerships, and on meeting applicable federal AHEC requirements. It is anticipated, however, that in time these AHECs will assume responsibility for their own growth and for meeting health care needs of their communities, which transcend those that can be addressed by the federal AHEC cooperative agreement. The local AHECs–as independent corporations–will be able to seek resources and carry out programs in addition to those supported by the federal AHEC monies.

Mission statement

The mission of the Wisconsin AHEC System is to improve access to health care in Wisconsin's underserved communities, through the development of community-based, client-oriented, culturally relevant, collaborative health professions education programs. The Wisconsin AHEC System accomplishes its mission by fostering cooperation and collaboration among Wisconsin's health professionals, educational institutions, and the communities.

Three major areas of focus emerge from this mission: building partnerships, interdisciplinary collaboration, and cultural relevance.

Building partnerships. The organizational and advisory structure of the AHEC project fosters the development of partnerships between the participating academic institutions and the target communities. The process of AHEC development has been designed to identify and nurture the values and interests shared by health professions faculty members and community leaders concerned with health care issues.

The AHEC project has also brought together health professionals representing different campuses and different disciplines. It has also established a new partnership between the Medical College of Wisconsin and University of Wisconsin-Madison Medical School, and has improved communication between the two medical schools and other health professions education programs, particularly in nursing and allied health. As the Wisconsin AHEC System

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Dr Gessert and Dr Cohen are from the Medical College of Wisconsin in Milwaukee, Wisconsin. Dr Gessert is vice chair of the Department of Family Medicine and Dr Cohen is associate director of the WISAHEC System. Dr Kritek is dean of the College of Nursing at Marquette University in Milwaukee, Wisconsin and is chair of the Nursing Task Force of the WISAHEC System. Dr Katcher is director of Community Health Programs and associate professor in the Department of Family Medicine and Practice at the University of Wisconsin Medical School in Madison. Dr Gessert and Dr Katcher serve as co-project directors of the WISAHEC System. Dr Kindig is chair of the Statewide Program Advisory Committee (SPAC) of the WISAHEC System and is also professor of preventive medicine at the University of Wisconsin Medical School. Dr Lobeck is associate dean of the UW Medical School-Madison and was, until recently, a co-director of the WISAHEC System. Moskol is director of the Office of Rural Health in the Department of Family Medicine and Practice at UW-Madison and is associate director and chair of the Rural Health Task Force of the WISAHEC System. Schramm is project manager for the WISAHEC System and is associated with the office of Community Health Programs at UW-Madison. Address reprint requests to: Charles E. Gessert, MD, Wisconsin AHEC System, 8701 Watertown Plank Road, Milwaukee, WI 53226. Copyright 1991 by the State Medical Society of Wisconsin.

develops, it should serve as a common pathway for many of the health-related concerns of state legislators, academic leaders, and communities.

Interdisciplinary collaboration. The Wisconsin AHEC System leadership recognizes that in many instances the health care needs of underserved communities require interdisciplinary interventions and that some of the state's most severe health care problems, such as teenage pregnancy, infant mortality, and substance abuse, are not amenable to resolution via discipline-specific models of care. Therefore, the Wisconsin AHEC System's planning process has emphasized the design of educational experiences that have maximum relevance to the needs of underserved communities and that focus specifically on the development of health professionals with the skills necessary to be effective in meeting these needs.

One response to this concern will be the establishment–by each of the AHECs in Wisconsin–of one or more Community Education Centers (CECs). Each CEC will be a small clinical training site which will provide multidisciplinary client-oriented services and educational experiences. Each CEC will emphasize one or more of the access problems of the clients of its site, such as access to health care for geriatric patient populations or for inner-city teenagers. Educational experiences provided in each CEC will be designed jointly by interdisciplinary faculty, with input from the community that is served by the site.

Cultural relevance. The Wisconsin AHEC System will support health professions education initiatives designed to increase the cultural sensitivity of health professions students and awareness of cultural issues in the delivery of health care.

The AHEC leadership recognizes that a significant barrier to access to care is that there are relatively few health professionals who are both willing and able to provide appropriate health care services to underserved populations. Our multicultural society is not producing adequate numbers of minority health professionals. As a result, all health care providers must increase their awareness of how culture affects health and health care use.

AHECs in Wisconsin will support two types of initiatives to improve minority populations' access to appro-

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priate care. First, AHECs will support programs that improve health career opportunities for minority students and programs that support career mobility for minority and disadvantaged students and indigenous professionals. Secondly, AHECs will support the development of curriculum changes, didactic materials, and clinical experiences that increase the cultural empathy of all students enrolled in Wisconsin's health professions education programs.

A major factor in the success of AHEC projects in enhancing the cultural relevance of the health profession's education is the development of good working relationships between campuses and target communities. The ongoing participation of these communities is a critical component of AHEC planning, selection of community-based clinical training sites, and evaluation of local AHEC programs.

Wisconsin's AHEC future

Federal support for the Wisconsin AHEC System will begin Oct 1, 1991. State support is also projected to begin in 1991. The AHEC System will build on the substantial progress that has been made in developing new strategies for making health professions education in Wisconsin more responsive to the needs of underserved areas. AHEC is built on a commitment to improve the relevance of health professions education. The AHEC concept transcends specific funding sources; when fully operational, it has the potential of serving as a clearinghouse for a range of programs and activities designed to improve health care.

In the long run, the Wisconsin AHEC System should be a powerful agent of institutional change, building enduring partnerships between campuses and communities.

The development of the Wisconsin AHEC System is an important step in improving the social influence of our health professions education programs, but it is not a panacea. The Wisconsin AHEC System will be developed within the context of challenges facing the whole nation. Mature AHECs such as North Carolina's continue to face serious problems: nursing shortages, allied health shortages, primary care physician maldistribution and ongoing need to develop minority health manpower.[4] Although AHEC will serve as an important partner in managing these ongoing problems, it will not resolve these single-handedly. With realistic expectations of AHEC, we will be able to recognize and celebrate its successes.

References

1. Carnegie Commission on Higher Education. *Higher education and the nation's health: Policies for medical and dental education*. Heightstown, NJ: McGraw-Hill Book Company;1970.
2. *Evaluation of the impact of the National Area Health Education Center Program: Final Report*. Submitted to Division of Medicine, Bureau of Health Professions, Rockville, MD. American Institutes for Research, Palo Alto, CA, 1990.
3. Gessert CE, Jones C. Urban AHECs: A comparison with rural AHECs. *Public Health Rep*. Nov, Dec 1986;101(6):637-643.
4. Mayer ES. The North Carolina Area Health Education Centers Program. *North Carolina Medical Journal*. 1989;50(12):660-664. ❑

News Notes

Physician shortage

Medical groups in the Midwest have the most pressing need for physicians, as Midwestern doctors cluster in cities and suburbs and leave large gaps in rural areas, according to *American Family Physician*. The percentage of groups with openings, according to region: Midwest, 41%; Southwest, 35%; Northeast 30%; Northwest, 30%; Southeast, 29%; and West, 20%. A nationwide survey found that if doctors could practice anywhere, their first two choices would be California and Florida.

Drugs R Us

Advertising Age reports a national poll that found that 86% of Americans have used headache remedies and other pain relievers in the past 6 months. Headaches are the chief reason (61.3%) for opening the medicine cabinet, followed by: muscle aches (13.6%), backaches (13.5%), colds (12.7%), arthritis or rheumatism (11.2%), menstrual cramps (8.7%), flu or fever (8.1%), heart attack prevention (3.6%), sleeplessness (3.2%), and oral discomfort (1.6%).

Doctor, talk to me

A recent survey, reported in *American Family Physician*, asked 1,000 Americans what they wanted most from their doctors, and 57% said "Clearly explain my choices for treatment." Other significant responses include: "Check with me for any questions I may have" (50%), "Ask me what I think is wrong with me" (50%), and "Be certain I have explained all of my concerns (49%). One in four has stopped seeing a least one physician because of communication problems.❑

Public health

Malignant mesothelioma in Wisconsin, 1959-1989

Henry A. Anderson, MD; Lawrence Hanrahan, MS; and Jerri Linn Phillips, MA, Madison

MALIGNANT MESOTHELIOMA is a rare tumor arising in the pleura, peritoneum and occasionally the pericardium. Pleural mesotheliomas account for approximately 80% of these malignancies. The ratio of males to females is about 3:1. Uniquely, it is usually associated with identifiable occupational or environmental exposure to asbestos. The high asbestos attributable risk has resulted in malignant mesothelioma being identified as a sentinel occupational and environmental disease event.[1]

When asbestos exposure is implicated, the latency time between first asbestos exposure and the onset of disease is almost always greater than 10 years and commonly 30 to 40 years. Thus, the disease we are recording today is typically related to exposures begun in the 1930s to 1970s. The mean age of cases is usually 60 to 70 years. The unusual characteristics of this disease and its public health importance as a sentinel event have resulted in mesothelioma registries being established in many countries.[2]

Currently, no national occupational exposure or disease surveillance program exists in the United States. This has hampered our ability to characterize the effects of past and future work site exposures on the public's health. Congressional testimony in 1984,[3] and later a 1987 report from the National Academy of Sciences,[4] detailed the deficiencies.

To assess the potential for establishing occupational and environmental disease surveillance in Wisconsin the Wisconsin Department of Health and Social Services (DHSS) entered into a 5-year (1984-1988) capacity building cooperative agreement with the National Institute of Occupational Safety and Health (NIOSH). The intent was to evaluate existing Wisconsin data systems for their use in occupational disease and injury surveillance. Selective sentinel disease pilot surveillance was initiated.

In 1987, the surveillance activities were expanded under the NIOSH Sentinel Event Notification System for Occupational Risks (SENSOR) initiative to include sentinel physician reporters and investigative intervention. This program was detailed in two earlier *Wisconsin Medical Journal* articles.[5,6]

Mesothelioma surveillance

With the assistance of the NIOSH project, a mesothelioma surveillance system was established using the existing computerized Wisconsin Vital Statistics Registration System (VSRS) data (1959-current) and the Cancer Reporting System (CRS) (1978-current).

Descriptive statistics

The mesothelioma surveillance system (1959-1989) contains 573 mesothelioma reports (160 females and 413 males). This includes 410 deaths with mesothelioma identified as an underlying or contributing cause of death. The CRS contains an additional 77 deaths among those with diagnoses of mesothelioma for which the death certificate did not specifically mention mesothelioma. The vital status of the remaining 85 is unknown, representing living cases or those who died after becoming residents in other states.

Because the CRS was not in existence for all the years covered by the surveillance system, mortality occurrence trends were examined using only the VSRS identified cases, (Fig).

Epidemiologic analyses using death certificate characterization of usual occupation and industry have been useful in occupational and envi-

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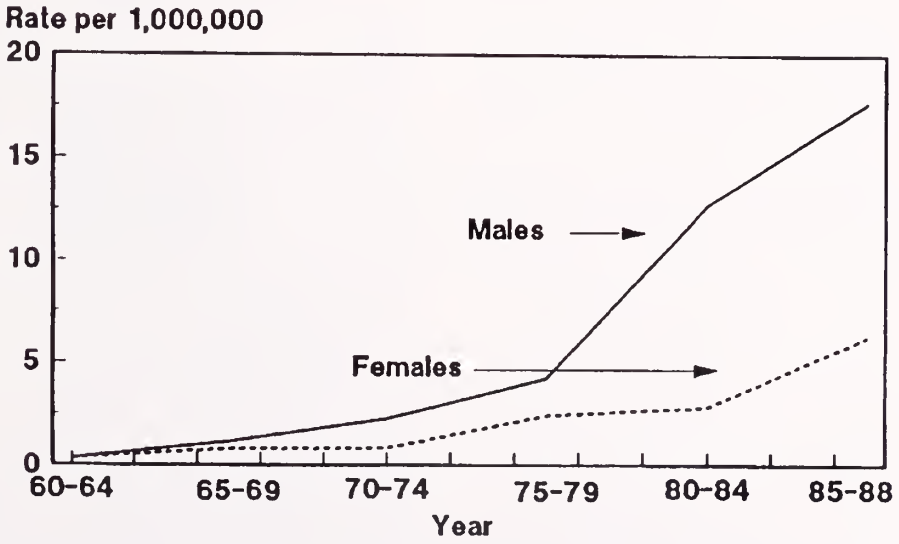

Fig.–Malignant mesothelioma in males and females; annual crude rates, 1960-1988.

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ronmental health research.[7] Usual occupation and industry as listed on the Wisconsin death certificate is included in the mesothelioma surveillance system. This information is a useful starting point for understanding which Wisconsin occupations and industries may have involved past asbestos exposures (Table).

Major occupational groupings of 483 Wisconsin malignant mesothelioma deaths, 1959-1989.

Industry/occupation	# Males	# Females	Total
Shipyard workers	9	0	9
Asbestos insulators	7	0	7
Asbestos products	2	1	3
Utilities	11	0	11
Construction	62	0	62
Maintenance/custodial	33	1	34
schools	11	0	
Manufacturing	112	13	125
Service industries	73	45	118
teachers	7	6	
Other	38	76	114

Comment

The Midwest has often been thought to be at low risk for asbestos-related diseases largely because it lacked the concentration of asbestos product manufacturing industries and large naval shipyards found in coastal areas.[2] While Wisconsin was never a major manufacturer of asbestos products, a small shipbuilding industry has been in Wisconsin since before World War II. The asbestos hazard of Wisconsin shipyard work is reflected in the nine cases listed in the Table. Asbestos containing products were widely used in the state. Much of the pipe and boiler as well as surfacing and other construction material which contains asbestos still remains in place.

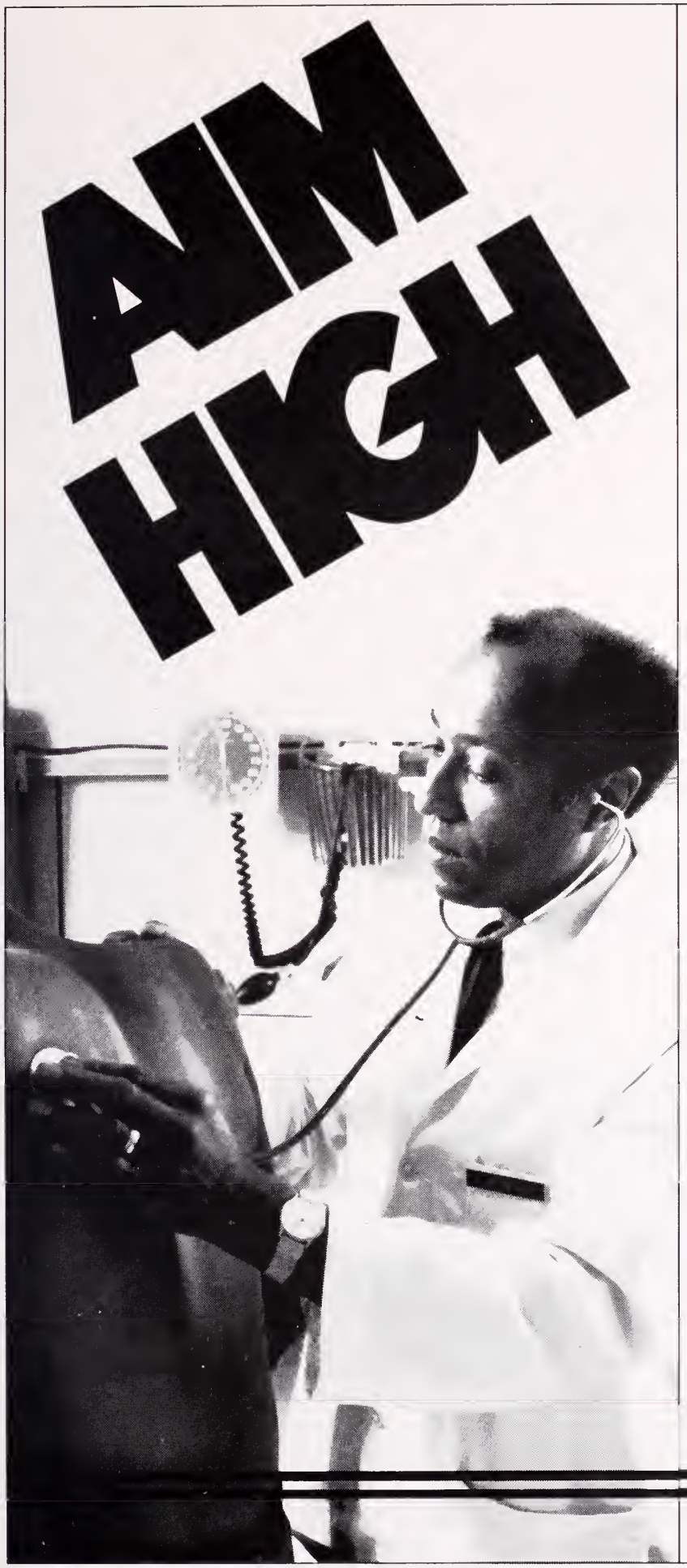
Wisconsin workers have not been exempt from asbestos exposure and mesothelioma. Wisconsin has experienced a markedly increasing prevalence of mesothelioma deaths over the past 30 years. While greatest among males, the increase is seen among both sexes. Our observation is consistent with worldwide reports. The crude death occurrence rate among males rose from .2 X 10^6 in 1960-1964 to 16.8 X 10^6 in 1985-1988. In females, the corresponding increases were from .3 X 10^6 in 1960-1964 to 6.1 X 10^6 in 1985-1988.

From the death certificate information alone it is often not possible to ascertain all past asbestos exposure. Although labor intensive and time consuming, it is feasible to reconstruct lifetime occupational histories. Medical record occupational histories (since 1983, all Wisconsin inpatient medical records must contain an occupational history) augmented by interviews with next of kin and treating physicians can provide information to better identify asbestos exposure potential which occurred over a working lifetime. The surveillance system has begun this task. Our in-depth investigation has begun with the mesotheliomas deaths where the death certificate occupation and industry information indicated school maintenance, public building maintenance, private building maintenance and factory maintenance employment. Because of the public attention on the asbestos in schools program, we also investigated the occurrence of mesotheliomas among school teachers.

Wisconsin has participated in the worldwide epidemic of mesothelioma. While the recent Environmental Protection Agency Rules will virtually remove from the market all new products containing asbestos, this will not eliminate future asbestos exposures. Today's work force will need training and protection from exposures which can occur during maintenance, repair, renovation, and finally demolition of already in-place materials. Physicians must maintain careful occupational and environmental histories on all their patients. When the potential for asbestos exposure is identified the physician must be sure the individual has been informed of the risks and provided with appropriate protection.

References

1. Rutstein DD, Mullan DJ, Frazier TM, et al. Sentinel health events (occupational): a basis for physician recognition and public health surveillance. *AJPH* 1983;73(9):1054-1061.
2. McDonald AD. Mesothelioma registries in identifying asbestos hazards. *NYAS* 1979:441-454.
3. US Congress, House of Representatives. Report on occupational illness data collection: fragmented, unreliable, and seventy years behind communicable disease surveillance. *GPO*, 1984.
4. Pollack ES, Keimig DG (eds). Counting injuries and illnesses in the workplace: proposal for a better system. Committee on National Statistics. National Academy Press, Washington DC, 1987.
5. Anderson HA, Remington PL, Hanrahan LP, et al. Surveillance of environmental disease: the Wisconsin initiative. *Wis Med J* 1990;89(3):120,122,124.
6. Hanrahan LP, Higgins D, Anderson H, et al. Project SENSOR: Wisconsin surveillance of occupational carpal tunnel syndrome. *Wis Med J* 1991;90(2):80,82-83.
7. Milham, S, Jr. Occupational mortality in Washington State, 1950-1971. Volumes I-III. US Department of Health, Education, and Welfare: HEW (NIOSH) Publication No. 77-189, 1976.❑



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AIR FORCE

HMO financial reports

THE YEAR-END STATEMENTS for the first quarter of 1991 for Wisconsin's HMO's are outlined in the following chart. The report was provided by the Office of the Commissioner of Insurance (OCI). Numbers do not tell the whole story, so physicians requiring further information should contact either the OCI or the chief financial officer of the HMO in question.

Recognizing that the report does not give physicians current or perfect information on the HMO's financial performance or stability, and that recent legal changes have increased the incentive for HMO's to enter into hold harmless agreements with physicians, the State Medical Society sought to provide greater accountability of HMO administrations to their contracting physicians.

WMJ will publish the quarterly financial statements of Wisconsin HMO's and future articles explaining the hold harmless law and how best to respond to it.

Office of the Commissioner of Insurance HMO 1991 annual statement summary–1st quarter–unaudited.

	Total Assets	Total Liabilities	Net Worth	Total Revenue	Total Expenses	Net Income	Enrollees
Aetna	1,567,591	1,027650	539,941	37,836	37,836	0	0
Compcare	30,988,652	22,633,206	8,355,446	46,377,071	45,621,908	585,065	158,267
Dean	37,377,546	26,519,031	10,858,515	35,325,732	36,136,657	(811,825)	115,784
Family	47,151,404	24,836,586	22,314,818	29,150,254	28,445,950	704,304	90,087
GHC-EC	6,213,429	5,120,899	1,092,530	5,087,535	5,574,881	232,654	17,297
GHC-SC WI	16,500,934	10,917,935	5,582,999	9,991,109	9,347,401	643,708	34,830
GLHP	1,583,981	892,179	691,802	1,339,818	1,291,938	43,880	5,150
HMO Midwest	4,988,103	2,962,716	2,025,387	2,776,891	2,564,172	212,719	9,132
HMO of WI	8,868,232	5,338,409	3,529,823	11,809,913	11,087,241	440,620	37,963
MHSIC	2,640,794	663,250	1,977,544	535,419	524,225	11,194	2,584
Maxicare	3,879,697	1,001,808	2,867,889	5,601,130	5,492,129	109,001	19,531
Med Assoc	919,399	121,052	798,347	1,025,544	968,480	57,064	2,802
Metlife	2,017,866	946,769	1,071,097	1,075,994	1,258,044	(182,050)	2,679
Midelfort	5,828,481	3,912,691	1,915,790	6,108,728	5,875,905	144,217	20,189
Network	4,197,345	3,139,524	1,057,821	6,888,629	6,654,320	148,440	25,323
NCHPP	13,800,987	9,115,170	4,685,817	9,878,743	9,829,758	48,985	33,292
Phys Plus	10,657,950	8,307,488	2,350,462	18,315,105	18,052,766	157,386	62,163
Primecare	32,020,560	26,495,474	5,525,086	28,271,803	27,479,698	759,648	92,151
Samaritan	16,741,530	12,298,488	4,443,042	19,757,233	19,671,626	79,386	67,031
Security	21,096,505	16,505,394	4,591,111	24,238,556	23,864,604	373,952	73,105
U-Care	5,704,706	3,195,465	2,509,241	4,570,801	4,088,224	482,577	15,548
United	3,769,889	2,682,589	1,087,300	4,166,966	4,106,714	60,252	15,978
WHOIC	31,088,204	24,057,277	7,030,927	39,256,192	37,697,846	1,096,423	132,905
EHIC	N/A	N/A	N/A	9,147,740	9,134,219	8,018	30,596
Q-Care	N/A	N/A	N/A	2,875,009	2,785,809	89,200	9,004
Allhealth	N/A	N/A	N/A	650,965	649,360	1,605	1,743
WHPP-EC	N/A	N/A	N/A	695,191	722,992	(27,801)	2,154
WHPP-Gr Bay	N/A	N/A	N/A	5,775,058	6,757,238	(982,180)	14,991
WHPP-Oshk	N/A	N/A	N/A	1,160,775	1,331,012	(170,237)	2,876
WHPP-WisRap	N/A	N/A	N/A	436,653	484,867	(48,214)	1,098

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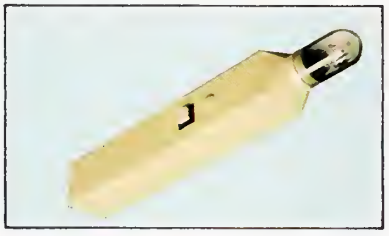

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Marilyn Marquardt
Head Nurse, Riverview Family Birthplace (LDRP)
Riverview Hospital, Wisconsin Rapids

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MD 2000

Wisconsin doctor selected as national symbol of physicians' sacrifices

Susan Bautch, AMA-WI project coordinator

KEVIN J. FULLIN, MD, winner of a 1991 SMS Physician-Citizen of the Year award, is now receiving national recognition for his efforts on behalf of domestic violence victims. Dr Fullin has been selected as one of four physicians to be profiled in *Time*, *Newsweek*, and *U.S. News and World Report* as part of AMA-sponsored program to highlight the strengths of American medicine.

The program, "Member Driven: 2000," will give Dr Fullin and three other physicians the opportunity to tell more than 73 million Americans about their work, their patients' needs, their dedication to their profession, and their commitment to the health of America. The campaign's goals are to improve the physician image and strengthen the physician-patient relationship by profiling physicians who are "making a difference for their patients, for all patients," according to James Todd, MD, the AMA's executive vice president. "These champions of professionalism are upholding the highest standards of our profession and helping those most in need."

The physicians were selected on the basis of their efforts with one of the public health issues on the AMA's health care agenda: interpersonal violence, AIDS research and treatment, care of the underserved, substance abuse and biomedical research. Each profile starts with the doctor's personal agenda, moves to the larger public health issue, and concludes by providing an AMA resource for further information on the topic.

Collateral advertisements, focusing on these four physician's motives for joining the AMA, will appear concurrently in leading medical journals across the nation, including the *New England Journal of Medicine*, *Medical Economics*, *JAMA*, *AMNews*, and the various medical specialty *Archives*. Many state medical journals will also run the ads as a public service.

Dr Fullin, 36, a Kenosha cardiologist, has worked tirelessly with local organizations and state officials to coordinate a hospital based advocacy program which assists victims of domestic violence. The program, based at St Catherine's Hospital in Kenosha and co-sponsored by Women's Horizons, Inc (a Kenosha

Continued on next page

Kevin J. Fullin, MD, of Kenosha.

This photo of Dr Fullin will be used as part of the MD 2000 effort to teach the public about the sacrifices physicians make.

Continued from preceding page
shelter for battered women), is the first of its kind in the state and one of only a handful in the country.

Dr Fullin said the impetus for coordinating an advocacy program came 2 years ago, when he heard an official from Women's Horizons speak on the topic of domestic violence. He then began to research the issue further and brought the matter to the attention of the Kenosha County Medical Society, of which he is a member.

"What we saw," said Dr Fullin, "were some very disturbing statistics regarding this issue, and we knew that we–as an organization–had to do something to curb this trend." Dr Fullin cited data he found in a 1984 issue of *JAMA*: "30% of all injuries of women presented to emergency rooms are related to some type of domestic violence." He also reviewed information from research conducted by former US Surgeon General, C. Everett Koop, MD, that stated "domestic violence accounts for more injuries to women than auto accidents, muggings and rapes combined and more than 4 women per day are killed as a result of domestic violence." Information received from the FBI showed that "in the United States, a woman is beaten in her home once every 12 seconds."

"We looked at these nation-wide numbers" Dr Fullin said, "and knew that Kenosha was no different than any other city. We knew we had to do something in our area."

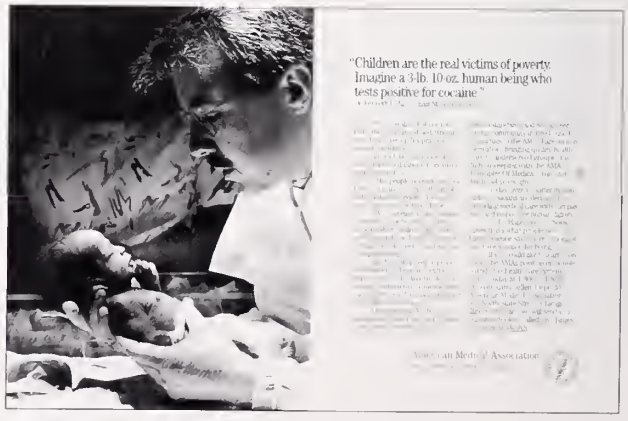
"We learned that women who are victims of domestic violence were more likely to go to a hospital for assistance than to a shelter or any type of law enforcement agency. We then knew that the hospital was the place for us to focus our energies."

The St Catherine's program, in its second month of operation, has three full-time advocates on staff working throughout various departments in the hospital. The advocates help educate all health care workers at the facility on methods of detecting domestic violence. They also provide counseling and support for domestic violence victims.

"The emphasis of this program," Dr Fullin said, "is that all health care workers are trained in asking the right questions when treating these victims." He explained that no physician would ever discharge a patient with a life-threatening illness after seeing him or her in the emergency room. Yet, repeatedly women are treated for broken bones and serious cuts and then sent back home, without the root of the problem being identified.

"We send them right back into the environment that could maim or eventually kill these women," Dr Fullin said, "We need to be asking the appropriate sensitive questions to identify the problem and help these patients."

The program is currently funded for 1 year with private donations from St Catherine's Hospital, the Dominican Sisters affiliated with St Catherine's and an unidentified individual donor. Dr Fullin, working through State Rep Peter Barca (D-Kenosha) and State Sen Joe Andrea (D-Kenosha), introduced a measure in the state budget bill that would continue funding of the



An example of an MD 2000 testimonial ad.

Kenosha program for another year, as well as provide funding for an additional program to be created in a rural Wisconsin community. Other legislators, such as State Rep John Antaramian (D-Kenosha) helped with passage of the measure. Gov Tommy Thompson, however, vetoed the funding for this program.

"I'd like to be able to use our experiences to help victims of domestic violence throughout Wisconsin, not just in Kenosha," Dr Fullin said. "The three advocates and I would like to create a liaison with other hospitals in the state and help put together victim advocacy programs so that others don't have to struggle alone with training and protocol problems."

On receiving the national recognition from the AMA, Dr Fullin said, "I was thrilled and honored but, I didn't do it alone. I feel the recognition represents not only my efforts, but those of all my Kenosha County colleagues who stood up with me on this initiative." He added, "I think what needs to happen in medicine is that physicians need to continue to stand up for programs that are going to benefit the people in their communities. This is happening in Kenosha, and I'm very proud to be a part of it."❑

Physicians interested in coordinating a hospital based domestic violence advocacy program are encouraged to call the St Catherine's program for more information at (414) 656-3339. For more information about the AMA or "Member Driven: 2000," call Susan Bautch at (608) 257-6781 or (outside the Madison area) 1-800-362-9080.

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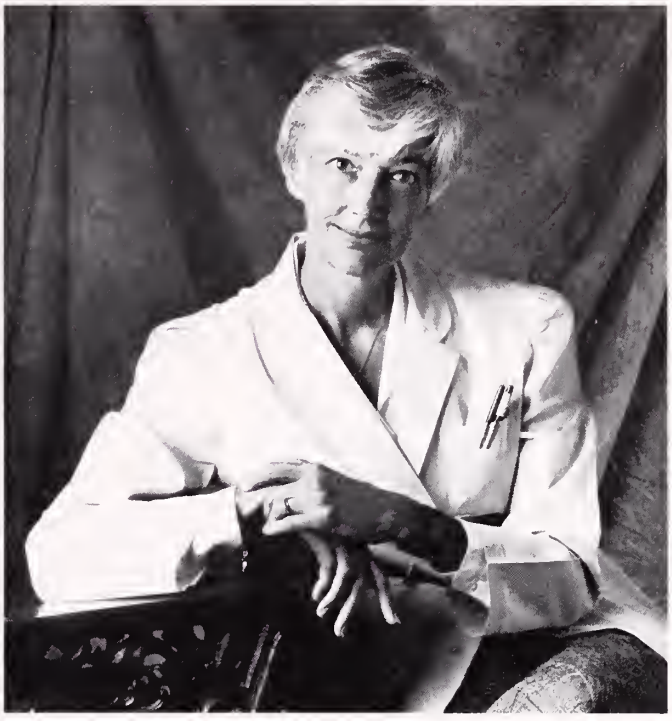

Join The AMA.

"I think one of the greatest contributions of the AMA is its activities on behalf of the most vulnerable in our society, children.

"The AMA adolescent health program is a great benefit to physicians who practice adolescent medicine and to policy-makers. But there is so much more that needs to be done. The AMA deals with the seemingly countless number of issues confronting medicine. And because it does, it gives me a great feeling of hope about the future.

"I can't imagine what the state of medicine would be without the AMA."

Join Dr. Kay Hanley, Pediatrician, in the American Medical Association. Call this toll-free number now.

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American Medical Association

Physician briefs

The * indcates an SMS member.

Kevin B. Scammell, MD, of Grafton, has joined the Milwaukee Medical Clinic Department of Pediatrics at its Cedar Creek and Port Washington centers. A pediatrician, Dr Scammell will join pediatricians **Thomas Chatton, MD,** and **John Geotz, MD.**

Neal Flomenberg, MD, of Milwaukee has been appointed scientific director of the Bone Marrow Transplant Program at the Medical College of Wisconsin. A nationally recognized cancer researcher, Dr Flomenberg will be based at the Milwaukee County Medical Complex. Dr Flomenberg was an associate attending physician at Sloan-Kettering Cancer Center and associate professor of medicine and immunology at Cornell University Medical College in New York. Dr Flomenberg served his residency in internal medicine at Albert Einstein College of Medicine followed by a research fellowship at Sloane-Kettering Institute for Cancer Research.

Robert Nagle, MD, of Mount Hope, recently began practice in the Ken-Bar Professional Building in Fennimore. A family practitioner, Dr Nagle will specialize in sports medicine, geriatric medicine and manipulative medicine.

Jyme Schafer, MD, of Evansville, has begun practice at the Dean Medical Center Evansville Clinic. A family practitioner, Dr Schafer received her medical degree from the Medical College of Virginia and completed her residency at the Blackstone Family Practice Center Richmond, Va.

Ann Berlage, MD,* of Beaver Dam, assumed the medical practice of **Richard Damon, MD.*** A family practitioner, Dr Berlage received her medical degree from the Medical College of Wisconsin and served her residency at the University of Wisconsin-Madison.

Ralph Huset, MD, of Frederic, recently joined the Indianhead Medical Center. Dr Huset received his medical degree from Stanford University.

Durward A. Baker, MD,* of Wauwatosa, was recently honored by St Joseph's Hospital for 25 years of service as a member of its medical staff. Dr Baker has held professional memberships in the AMA, American Psychiatry Association, Wisconsin Psychiatry Association, and the SMS. Dr Baker is a clinical professor in psychiatry at the Medical College of Wisconsin.

Pedro Lucina, MD, of Neillsville, recently joined the Memorial Medical Center. A general practitioner and surgeon, Dr Lucina comes from the Chicago area.

Robert Turner, MD,* of Reedsburg, recently joined the Reedsburg Area Medical Center. A cardiologist and internal medicine specialist, Dr Turner had been in private practice in Carmel, Ind.

County society news

Brown. At the May meeting of the society, professor Martin Greenberg, of the University of Wisconsin, Green Bay, spoke on "After Desert Storm, what next?" Richard B. Windsor Jr, MD, of Green Bay, was accepted to membership.

Rock. At the February meeting of the society, guest speaker was Mary McBride of Janesville. Her speech was entitled "Humor - A Healing Strategy." New members elected to membership were Merle Teetzen, MD, Stuart Olson, MD, and Thomas Cunningham, MD. At the business meeting, the amended constitution and by-laws of the society were accepted.

Winnebago. At the April meeting of the society, 32 members were present to hear Robert Weber, MD, of Oshkosh, speak on management of blunt trauma. George Arndt, MD, of Neenah, gave a premiere showing of the videotape program recently prepared concerning the functions of the Medical Examining Board. The issue of unfilled or newly created vacancies for delegates and alternate delegates to April SMS annual meeting was discussed.

Winnebago. Thirty-nine members were present at the May meeting of the society. Prior to the beginning of the formal business meeting, a presentation on domestic abuse, provided by the Regional Domestic Abuse Services, Inc was heard. This was a general discussion of the services they provide in their capitol campaign program they are currently in. A second presentation on hearing loss was conducted by Juliette Sterkens and Doreen Jensen. The discussion concerned the 18 to 20 million Americans currently suffering hearing loss, the diagnostic modalities available for it, and the therapeutic interventions possible to treat it. The next meeting will be in September.❑

Henry A. SanGerman, MD, of Two Rivers, has joined the Two Rivers Clinic, Ltd. A family practitioner, Dr SanGerman received his medical degree from the University of Illinois College of Medicine. He completed his residency at the University of Texas Southwestern Medical Center.

Antoinette Zell, MD,* of Beloit, recently joined the Beloit Memorial Hospital Emergency Department. A graduate of the Medical College of Wisconsin, Dr Zell completed her residency training at Baylor Collee of Medicine and the University of Health Sciences-Chicago Medical School.

Stephen Thomas, MD,* of Sun Prairie, recently joined the Sun Prairie Clinic. A family practitioner, Dr Thomas received his medical degree from the State University of New York. He served his residency at the University of Iowa Family Practice Residency Program in Iowa City.

Richard B. Windsor, MD,* of Green Bay, recently joined **Charles W. Troup, MD,*** in the practice of pediatric and adult urology. A graduate of the University of Wisconsin Medical School, he completed a general surgery residency at the Medical College of Wisconsin and a uroloic surgery residency at the Hershey Medical Center in Hershey, Penn.

Gwen A Johnson, MD, of West Bend, recently joined the General Clinic. Dr Johnson is a family practitioner.

Brian J. Eggener, MD,* of Manitowoc, recently opened a psychiatric practice in Manitowoc. Dr Eggener recieved his medical degree from the University of Wisconsin Medical School.

Vincent T. Miller, MD, of Chippewa Falls, recently joined the Marshfield Clinic-Chippewa Center. A physician specialist, Dr Miller received his medical degree from the University of Illinois College of Medicine. He completed a neurology residency at Northwestern Memorial Hospital in Chicago, and a cerebrovascular fellowship at Oregon Health Sciences University in Portland.

William Raduege, MD,* of Woodruff, was recently named Physician of the Year by the Wisconsin Academy of Family Physicians. A member of the SMS, Dr Raduege has served on the SMS Board of Directors and has served on the SMS task forces on rural health care, and health care cost containment, and on the Commission on Mediation and Peer Review. Dr Raduege received his medical degree from the University of Wisconsin Medical School, and served his internship at St Luke's Hospital in Duluth and his residency in general surgery at Lutheran Hospital and Gundersen Clinic in La Crosse.❑

Physicians heed RBRVS call to action; members of Congress express concern

WISCONSIN PHYSICIANS and medical group managers have met with, written, and called their representatives and senators, to express their concern and anger over the Health Care Financing Administration's proposal for implementation of a new Medicare payment system for physician's services. HCFA's proposed implementation of the Resource-Based Relative Value Scale (RBRVS) would violate agreements that the changeover be "budget neutral," and instead, would actually reduce Medicare payments by up to $3 billion annually.

In addition to providing comments to HCFA, Wisconsin physicians have sought assistance from Wisconsin's Congressional delegation, since action by Congress may ultimately be necessary to revise HCFA's plan. Thus far, Wisconsin's senators and representatives have been receptive to the concerns raised, noting that states like Wisconsin would fail to realize the anticipated improvements in payments for primary care, and in rural areas, these improvements, in turn, were expected to improve Medicare patients' access to care, especially in rural states.

To date, Representatives Toby Roth, David Obey, Tom Petri and Scott Klug have all indicated that they intend to contact HCFA and the US Department of Health and Human Services (DHHS), expressing their concern with HCFA's proposal. Sen Herb Kohl has also written to DHHS Secretary Louis Sullivan, MD, reaffirming Congressional intent and stating he was concerned with "such drastic, first-year cuts in reimbursement as suggested by the HCFA regulations."

Rep Toby Roth wrote to all other members of the House addressing the problem with HCFA's proposed regulations, noting that HCFA's proposal imposes an "arbitrary and unjustified 16% reduction in the 'conversion factor."❑

SMS president speaks out against AIDS hysteria

SMS President Cyril M. "Kim" Hetsko, MD, of Madison, has been travelling the state visiting with local and statewide media to discuss the Society's position on HIV testing of health care workers. The visits were prompted by discussion of the issue at the AMA annual meeting in late June, the July release of the Centers for Disease Control (CDC) guidelines for HIV-infected health care workers, and two HIV-related amendments approved by the US Senate in July.

The first amendment imposes prison terms of at least 10 years and fines up to $10,000 to a health care worker who knowingly has the virus and provides medical or dental treatment to a patient; the second amendment requires states to implement the CDC guidelines or be denied assistance under the Public Health Service Act.

The SMS strongly opposes the amendment because it would criminalize the disease and move dangerously close to mandatory testing. During his recent media visits, Dr Hetsko reminded the press and the public that there has been no proven transmission of HIV from a physician or nurse to a patient. The only known modes of transmission are exchange of blood or body fluids visibly contaminated with blood, most commonly through needle sharing, sexual contact, and from mother to child.

For years, the SMS has recommended voluntary testing for anyone who may be at risk for HIV infection, including physicians and other health care workers, for the purpose of monitoring their own health. The SMS and the AMA have also encouraged any health care workers infected with HIV to request the creation of a local ad hoc committee to advise them on which clinical activities can be engaged in without posing any identifiable risks of infection to their patients.

In January 1991, the AMA adopted a new policy that says health care workers who are HIV infected or who have AIDS should either abstain from performing invasive procedures that pose an identifiable risk of transmission or tell their patients about their infection before performing such procedures and proceed only if the patients give informed consent. In July, the CDC issued similar recommendations to health care workers that also include: adherence to universal precautions such as appropriate use of hand washing, protective barriers, and care in the disposal of needles and other sharp instruments; identification of exposure-prone procedures by medical, surgical, and dental organizations; and becoming aware of their HIV status if the health care worker is performing exposure-prone procedures.

The SMS's Task Force on AIDS has created a booklet outlining the recommendations of the SMS and the task force. Issued in March 1991, the booklet was adopted by the SMS Board of Directors and is available free to members by calling 1-800-362-9080 or (608) 257-6781, ext. 302.□

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates member of the SMS.

May 1991

*Bernacki, Michael H., Green Bay
*Boedecker, Robert A., Brookfield
Bommakanti, Swami S., Oshkosh
*Boyle, Noel G., Milwaukee
*Carlson, Alan R., Cumberland
*Combs, James A., Monroe
Cusick, Joseph F., Milwaukee
Duffy, Thomas M., Kenosha
*Engstrom, Denton P., White Lake
Gardner, James D., Waukesha
*Giray, Erol F., Milwaukee
*Hathway, Stephen D., Green Bay
*Herdrich, Gary M., West Bend
Kampschroer, Bernard H., Brookfield
*Katt, Jeffrey, A., Bayside
*Kresge, Dean G., Stoughton
*Larson, Sanford J., Milwaukee
*Mateo, Raul, Milwaukee
*Maynard, James P., Milwaukee
*Meyer, Glenn A., Milwaukee
*Pawlak, James R., Sheboygan
*Rumbolo, Peter M., West Allis
*Stafl, Jaroslava, Milwaukee
*Vravick, Thomas E., Racine
Walsh, Patrick R., Milwaukee□

Obituaries

H. James Hamm, MD, 57, of Thiensville, died May 12, 1991, in Milwaukee. Dr Hamm was born Jan 16, 1934, in Milwaukee, and graduated from Marquette University School of Medicine. His internship was served at Milwaukee County General Hospital, and his residency was completed at University Hospital and Clinics in Madison. Dr Hamm was on the medical staff of St Mary's Hospital, Milwaukee, served as president from 1984-1985, and had been a member of the board of directors since 1987. He also had been the medical director of the A. O. Smith Corporation from 1966 to 1991. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Marjorie, two sons, Andrew and Adam, and one daughter, Julia.

G. Douglas Reilly, MD, 55, of Neenah, died May 29, 1991, in Neenah. Dr Reilly was born April 5, 1936, in Three Rivers, Mich, and graduated from the University of Michigan Medical School in Ann Arbor. Dr Reilly served his internship at Oakwood Hospital in Dearborn, Mich, and completed his residency at the University of Minnesota. He served as president of the La Salle Clinic and was a member of its pediatrics department. He was a member of the American Academy of Pediatrics, the Winnebago County Medical Society, the SMS, and the AMA. Surviving are his widow, Vera, a daughter, Linda, of Chicago, and a son, Steven, of Milwaukee.

Robert F. Purtell, MD, 82, of Wauwatosa, died June 8, 1991, in Wauwatosa. Dr Purtell was born Aug 4, 1908, in Monches, and graduated from Marquette University School of Medicine. Dr Purtell completed his internship and residency at Milwaukee County General Hospital. In 1943, Dr Purtell joined the faculty at Marquette School of Medicine and had served in a teaching capacity for many years. He served on the initial Blue Cross/Blue Shield insurance board of directors. In 1965, he served as president of the Medical Society of Milwaukee County. Dr Purtell was a member of the Wisconsin Academy of Family Physicians, the Milwaukee Academy of Medicine, the Marquette Medical Alumni Association, and the AMA. Active in SMS affairs, he served on many committees and commissions of SMS, and served as its president in 1972-1973. He retired from medical practice in 1985. Surviving are three sons, Robert, Dennis, and Michael; two daughters, Mary King and Anne Fitting; 16 grandchildren, and four great-grandchildren.❑

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑

CES Foundation report

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership dues statement from September 1, 1990, through May 31, 1991.

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Continued on page 493

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Continued from page 491

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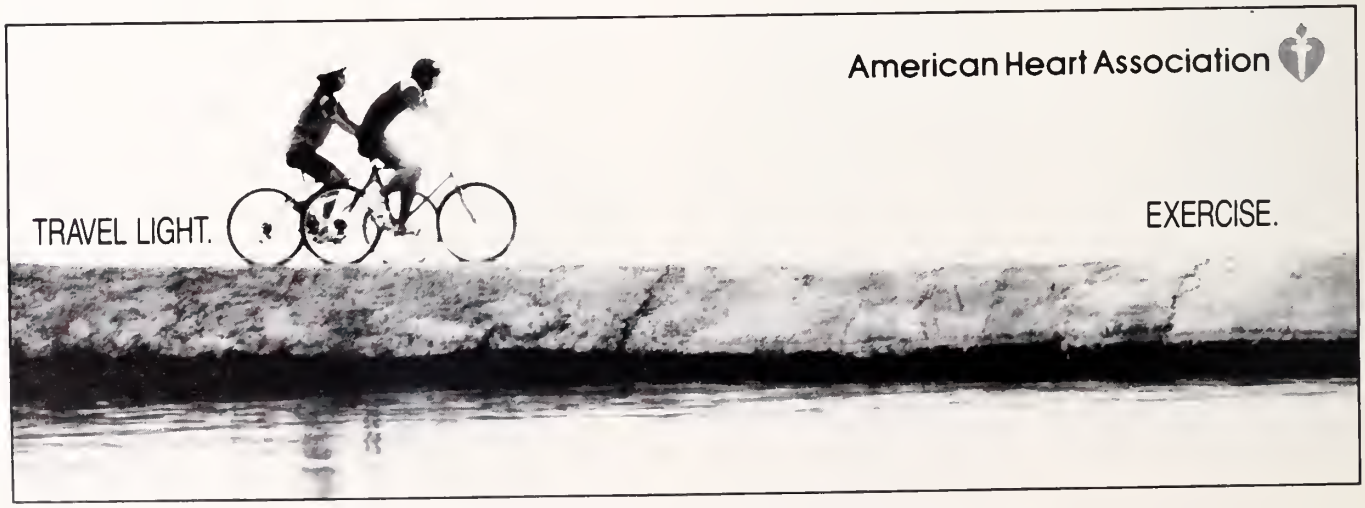

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SE Wisconsin pediatrics. Unique opportunity for 1-2 skilled BC/BE pediatricians. Hospital management and start-up assistance available along with coverage from skilled BC colleagues. Be part of a new practice in a prospering community close to Milwaukee, Madison, and Chicago. Contact Amy Palmer, Professional Relations Director, Waukesha Memorial Hospital; ph 1-800-325-2011. p8;9/91

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. c6-9/91

The University of Wisconsin-Oshkosh is seeking a staff physician for the University Health Center. This is a 9 month position (September thru May), office only practice, best suited to a family physician, pediatrician, or internist. It requires a license to practice medicine in Wisconsin. Malpractice, fringe benefits, and a salary of $50,000 per year are provided. Expected starting date is September 3, 1991. Contact the Director of Student Health at 414-424-2424 or submit a curriculum vitae to the UW-Oshkosh Health Center, Oshkosh, WI 54901-8694. 8/91

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Growing, four physician family practice in Oshkosh seeks another associate. Need is dictated by growth in the area and the practice. Each physician sets his own hours and pace and works about 4 1/2 days per week. The group will relocate into a new facility next year. If you enjoy water sports and recreation, Oshkosh is second to none. We also offer museums, symphony, quality schools, and two zoos. We are seeking a residency trained family practitioner who enjoys obstetrics. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Road, Suite 500, Atlanta, GA 30319, or call him at 800-347-7987, ext #1-145. 8/91

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Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes' office at 906-563-9255 or Dr. William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; 906-563-9243. 8-9/91

Wisconsin - Fox River Valley. Established nine-physician two-hospital group with 15 years longevity seeks BP/BC emergency physician to fill 10th position. The candidate will be offered a starting package of $165,000 with corporate membership in two years guaranteeing a $200,000 package. Benefit part of package includes 15% retirement, paid malpractice, health, dental, disability, and $4,000 per year CME. ED volume 27,000 per year, average shift 6 days/6 nights per month, 12 hours per day, double coverage with physician assistants. Interested candidates may apply in confidence to Fred W. Knoch, III, MD, FACEP, 445 Kittiver Court, Neenah, WI 54956;414-725-4639. p7-9/91

Milwaukee, solo, internal medicine practice, for sale! Retiring internist, creates opportunity to "walk into" established practice and excellent support staff. Adjacent to West Allis Memorial Hospital; expansion began for new, professional/out-patient facility. Added value from hospital's referral program, quality reputation, and community atmosphere. Send CV or call: Dale Wiza, NL/P, Ltd, 1343 Martha Washington Dr, Wauwatosa, WI 53213; 414-453-8999, 1-800-966-8999. 7-8/91

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Physicians Exchange

Continued

Full-time or part-time physician needed for women's health center. Salary negotiable. Partnership a possibility. If interested please forward a current CV to: Aleksander Jakubowski, MD, 5825 W. Capital, Milwaukee, Wisconsin 53216. p7-9/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 7-9/91

Door County, Wisconsin. One to two BC/BE internists to join hospital-based physicians' clinic. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Gerald M. Worrick, Administrator, 330 South 16th Place, Sturgeon Bay, WI 54235. p6-8/91

Seventeen-physician multi-specialty group needs FP, IM, OB/GYN and Peds. Located on the edge of the Ozarks only one hour from St Louis. Excellent community to raise a family. Excellent school systems and a service area of 200,000 residents. Excellent benefits. Contact Ronald Stevens, Administrator, Medical Arts Clinic, 301 West Liberty St, Farmington, MO 63640; ph 314-756-6751. 6-8/91

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Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, constructing new clinic and hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. 3tfn/91

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September 25-27, 1991: "The treatment of panic disorder," at the Masur Auditorium, The Warren Grant Magnuson Clinical Center, NIH, Bethesda, Md. Info: Conference Registrar, Prospect Associates, 1801 Rockville Pike, #500, Rockville Md 20852; ph 301-468-6338. g6-8/91

September 26-28, 1991: (Session I) & October 3-5, 1991 (Session II): Fourth Annual Update in Primary Care, at Landmark Resort, Egg Harbor. Sponsored by Medical College of Wisconsin, Division of General Internal Medicine. For more information, contact: Colleen Berg, 414-257-6040. 7-8/91

October 10-13, 1991; American Society of Internal Medicine 35th Annual Meeting at J.W. Marriott Hotel, Washington, DC. Category 1 CME credit will be available. Info: Lisa Derby at 202-289-1700, ext 615. g6-9/91

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

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December 8-11, 1991: Interim House of Delegates, Las Vegas.
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BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

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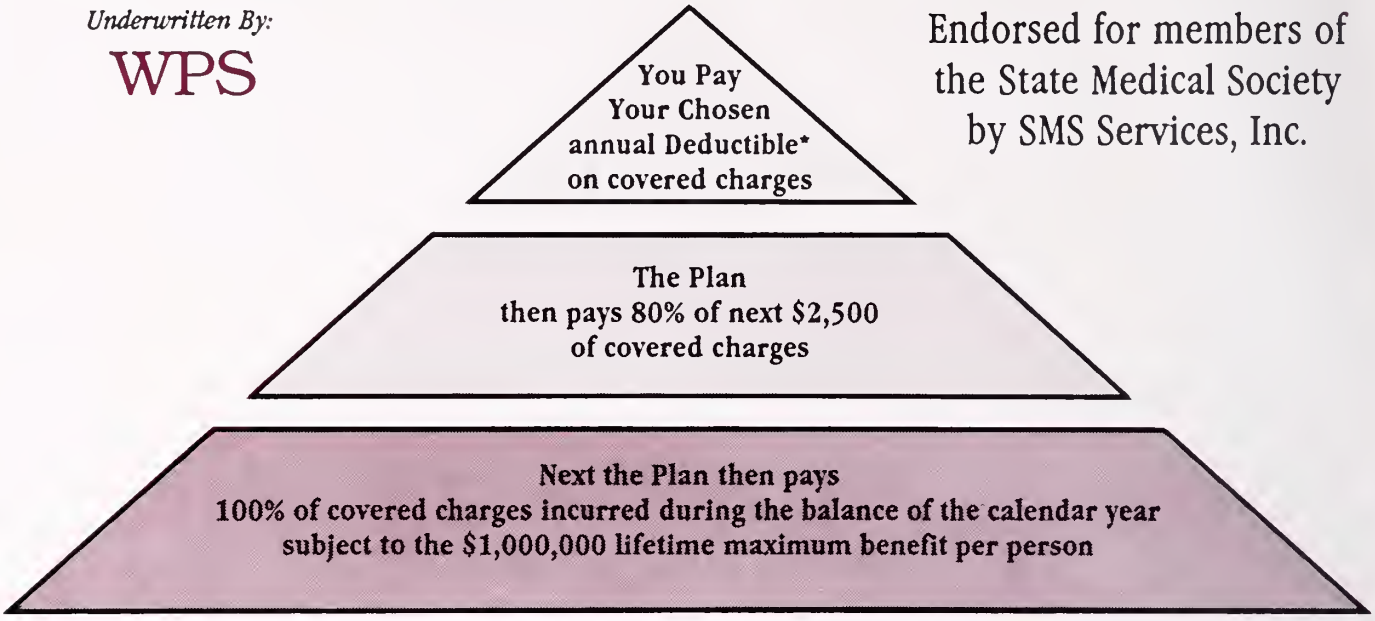

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Contents

September 1991 Vol. 90 No. 9

Opinions

503 *President's page*
The challenge to industry
'Medicina nusquam non est' (medicine is universal): IV
by Cyril M. "Kim" Hetsko, MD, Madison
504 *Secretary's report*
A most unforgettable physician
by Thomas L. Adams, CAE, Madison
506 *Letters*
Prior authorization a threat to doctor-patient bond
by Art Haymes, MD, Reston, VA
507 Don't worry, be stupid
by Vinoo Cameron, MD, Athens
509 *Soundings*
Late night call to 6 west
by Jonathon Temte, MD, Madison

Science

511 War and medicine in the desert:
A report of the 13th Evacuation Hospital in Saudi Arabia
by Guenther P. Pohlmann, MD, Milwaukee
516 Hearing impairment and the elderly patient
by Priscilla F. Bade, MD, Milwaukee
520 Characteristics of alcohol use by school children in a northcentral Wisconsin county
by Willard E. Pierce; Steven K. Broste, MS; and Peter M. Layde, MSc, MD, Marshfield
525 Severe illness associated with group A-hemolytic streptococcal infections
by Jay C. Butler, MD; Benjamin Schwartz, MD; Judy Kimball; and Jeffrey P. Davis, MD; Atlanta and Madison

Socioeconomic

531 Development and operation of the Wisconsin Research Network
by John W. Beasley, MD; Narra Smith Cox, PhD; Barbara Tenor Livingston, MPA; James E. Davis, MS, MD; Patrick McBride, MD; Terry L. Hankey, MD; Richard Shropshire, MD; and Richard G. Roberts, MD, JD, Madison
538 *Public health*
Breast cancer in Wisconsin: the potential for primary prevention
by Paula M. Lantz, MA, and Patrick L. Remington, MD, Madison
540 Reporting written policies on abortion
541 New fraud and abuse sage harbor rules go into effect

Organizational

543 The legend of a country doctor
by Russell King, editor
549 Highlights from the SMS Board meeting
549 SMS opposes proposed Medicare reductions for new physicians
550 Persian gulf physicians honored at SMS Board meeting
552 SMS meeting with HCFA is constructive
552 Physician briefs
554 Memorials made through the CES Foundation
557 SMS secretary-general manager hears physicians' concerns
588 Instructions to authors

Our cover: Snapshots from the 13th Evacuation Hospital from Madison serving in Saudi Arabia. Graciously provided by James E. Engeler, Jr., MD, of Madison.

Wisconsin Medical Journal

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

The challenge to industry

'Medicina nusquam non est' (medicine is universal): IV

AT BOTH THE STATE AND LOCAL levels, the Wisconsin business community has been taking an increasingly active role in looking at physician and hospital costs in an attempt to lower the costs they incur for their employees' health care. I challenge the business community to spend the same amount of time and energy on addressing the fundamental factors that all agree are driving up health care costs.

These factors include:

- the inefficiencies and inequities of the medical liability system;
- the plight of Wisconsin's uninsured;
- the lack of adequate government funding for Medical Assistance; and
- the lack of coverage for adequate primary and preventative care for some Wisconsin citizens.

These four problems, more than any others, drive up the costs of medical care by shifting the dollars lost and dollars unpaid to private payors, insurers, and businesses. Any cost-cutting efforts that do not include these factors are misguided, incomplete and doomed to failure.

The SMS has been working with the Wisconsin Manufacturers and Commerce, Wisconsin Association of HMOs, Wisconsin Association of Life and Health Insurers, and Wisconsin Hospital Association to find the cost-cutting measures that will work best for all involved. The work has been productive. The coalition developed a 12-point plan and the member organizations have been touting the plan's advantages to their members, civic leaders, members of the news media, and elected officials at all levels.

The plan is a good one and the oddity of the coalition has attracted some attention, so progress is being made. The progress is slow, however, because the responsible and efficient in life is never as glamorous as the irresponsible and the unworkable. Those who advocate easy quick fixes are garnering considerably more attention from the press, the public, and the politicians than those who are actually responsible for making the system work.

That overall reform is slow in coming should not, however, be used as an excuse to delay doing what we can–and know we should–do now. Not every facet of reform requires time nor merits lengthy debate. One of the most immediate concerns is our fellow citizens who are uninsured. Their plight is not merely increasing the cost of health care, it is also lowering the quality of life and driving up the toll of human suffering. The answer to this problem is in large part accessible to us now, if we are willing to reach out and seize it.

Cyril M. "Kim" Hetsko, MD

While I applaud the business community for its concerns and efforts to date, it must work on solving these problems and accept their obligation to their employees. I challenge all businesses in the state to provide, to the best of their abilities, at least modest health insurance coverage for their employees. Further study and more planning, will only lead to more excuses. As Bo Jackson, who is coming to know medicine a lot better, says: Just do it!

Medicina nusquam non est. Medicine is universal if only we are willing.□

Secretary's report

A most unforgettable physician

Thomas L. Adams, CAE

WHEN I WAS A GROWING UP, I could not wait for the next copy of *Reader's Digest* to arrive in the mail. While the humor pages appealed to my boyish sense of humor, the regular feature that interested me most was called "My most unforgettable character." The people in these articles were so fascinating, so amazing that they seemed almost mythological. I always hoped I would meet such a person, but I never really thought I would.

Over the years, I have met a great many interesting and remarkable people–presidents, governors, artists, writers–and not least among them are some of the physicians I have had the pleasure to work with over the past 15 years. But, now in my early 40s, I have finally met my most unforgettable character.

His name is William B.A.J. Bauer, MD–Dr Bill, as he is known throughout Rusk County. I met Dr Bill 3 years ago, when I was seated next to him and his lovely wife "Gussie" at the SMS dinner for physicians who had been in practice for 50 years. In the ensuing years, we have had an active correspondence that has touched on many areas, including nature, parenthood, friends, the joy of healing, medicine's past, medicine's future–it's a long list.

Dr Bill, now retired at age 80, has lived the sort of life that keeps the rest of us humble. He is a testament to the largely untapped potential of we humans. His strength has been matched by his endurance, his intelligence by his compassion, and his breadth of interest by his focus of purpose.

Dr Bill left Long Island, NY, to become a country doctor. Even Ladysmith, however, proved too urban for this city boy who had fallen in love with Wisconsin's wilds, so he built a forest around his home. That's right, a forest. Over the years he has planted–by hand–some 600 trees, mostly pines.

The acquisition of the trees tells us something about the man, too. Dr Bill often cared for rural patients who had no money, so he took trees in trade. Once, when a farmer delivered an enormous load of mature trees to the street next to his home, the doctor hired another man with a horse to haul the trees down the steep hill that defines the Bauers' backyard. After

Continued on page 506

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AIR FORCE

Continued from page 504
moving just two trees, the man quit the job saying that he didn't want to kill his horse. So, Dr Bill rigged up a harness for his own broad shoulders and moved those trees himself.

The main feature of the mini-forest is a trout pond fed by water flowing from a basement well through a homemade filter. In earlier times, Dr Bill conducted experiments on trout life cycles and growth in his homemade hatchery. (See page 543 of this *WMJ* for more on Dr Bill.)

The forest microcosm is a fitting monument to a man who did work that would kill a horse.

I have wondered whether there was anything beyond this man's abilities. Besides being a homespun engineer, forester, limnologist and philosopher, he is one of Wisconsin's foremost authorities on trout and trout fishing; a writer of books, scientific articles, children's stories, poetry and a weekly newspaper column; a loving husband and father of five; and a caring physician who earned the trust, respect and love of his patients. In conversation, his mind can leap from topic to topic and find interesting, sometimes profound, things to say about each.

Dr Bill is inspiring to me as a person, but I think he is also worthy of being an inspiration as a man of medicine. Young physicians, wherever they may practice, can look to Dr Bill as an example. That's the way it is in medicine: each generation builds on the progress of its predecessor; each generation owes its predecessor an enormous debt of gratitude and honor. Dr Bill applied the best medical science of his era with strong hands, open ears, and a loving heart. And even if the legend of Bill Bauer the man may fade with time, the example of Bill Bauer the physician should shine on for generations to come. ❑

Letters
Prior authorization a threat to doctor-patient bond

TO THE EDITOR: As a fellow physician, I must alert my colleagues to another evolving threat to our independent prescribing prerogatives, our considered judgements, and our moral commitment to the doctor-patient relationship.

Under the federal budget law passed in October 1990, state Medicaid formularies must include all prescription products of manufacturers who have signed drug rebate agreements. States may, however, require physicians to obtain official permission before a specific (and preferred) medicine can be dispensed. This cumbersome practice is identified as "prior authorization." In effect, it creates a second class of medicines, ie, prescribing for only those traditional and "non high-tech" medicines that do not require prior approval for Medicaid patients.

Prior authorization holds the potential to be a significant and far reaching threat to quality health care. It could create a second class medical care system for American's poor, as well as de facto state-wide restrictive formulary system. It intrudes into precious time that we devote to patients; it requires another obstructing bureaucratic layer in the therapy process, sandwiched between prescribing the most appropriate therapy for our patients and what the state regulates. Decision making in the doctor-patient relationship may soon include a new "silent player," one whose agenda is cost not quality, priorities not patients, and administration not advocacy.

This front ended deficit-reducing federal legislation has a negative back end effect upon the states. It erodes any cost savings by creating substantial state administrative costs for its implementation, ie, a DUR program, reporting processes, etc.

Intrusions into medical practices by those who presume to know, from afar, what's best for our patients is increasing. It is not in the patient's interest to tell physicians that medication we appropriately prescribe, may be given–if we jump through enough hoops. Prior authorization could well become one more disincentive to treat our state's Medicaid patients; it will be disruptive to office procedure; and is a form of bureaucratic harassment. The time is now to let our legislatures know that we continue to place quality care at the top of our medical agenda. What we think, what we know, or what we believe is of little consequence. What is important is what we do to improve patient care.

–Art Haymes, MD
Reston, VA

Editor's note: States had the power to require prior authorization for both drugs and procedures before passage of OBRA '90.❑

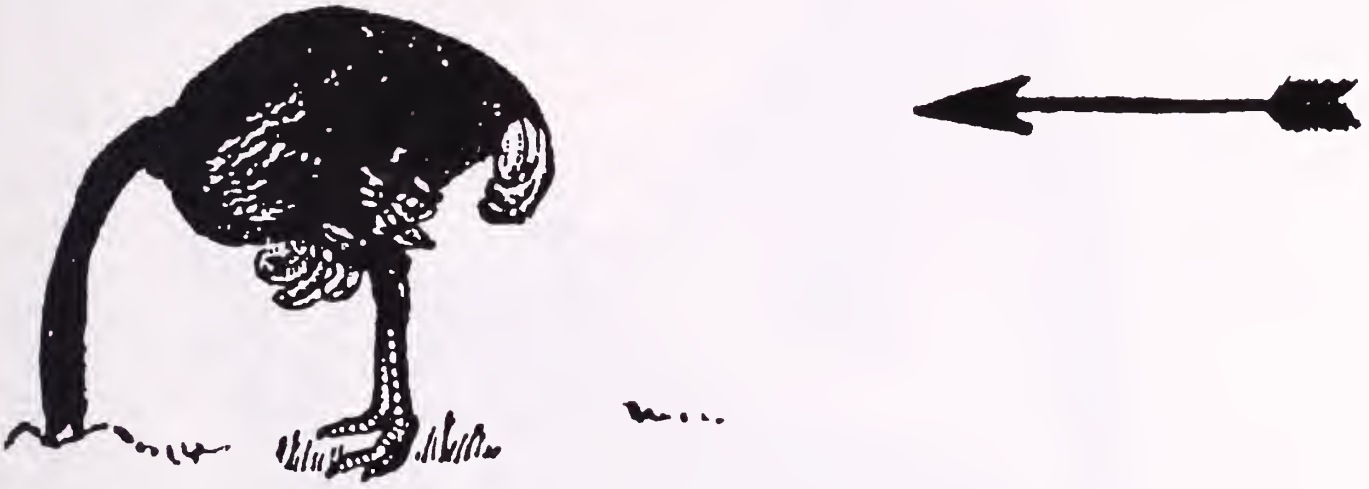
Don't worry, be stupid

TO THE EDITOR: I just did an employment physical on a young teacher, who had just finished his college training and was seeking a job. He informed me that it is mandatory for all new teachers to join the teacher's union and there is absolutely no choice. Without the membership, you cannot land a job.

It reminded me as to how privileged we are as physicians not to be forced to belong to a medical society or a medical organization or a union. Yet how many of us actively get involved in local medical societies or state medical societies? All that can change unless one is like a physician I met at a recent CME conference with a button that read, "Don't worry, be happy." Just the other day I saw a button in the store, "Don't worry, be stupid." Come on, colleagues, let's get seriously involved in our medical societies.

To Our Readers:

The 1990s are and will undoubtedly continue to be difficult years for private medical practice. To cope, it's important that you be well-informed, planning your course as well as you can. This cartoon shows the opposite approach:



–Vinoo Cameron, MD
Athens ❑

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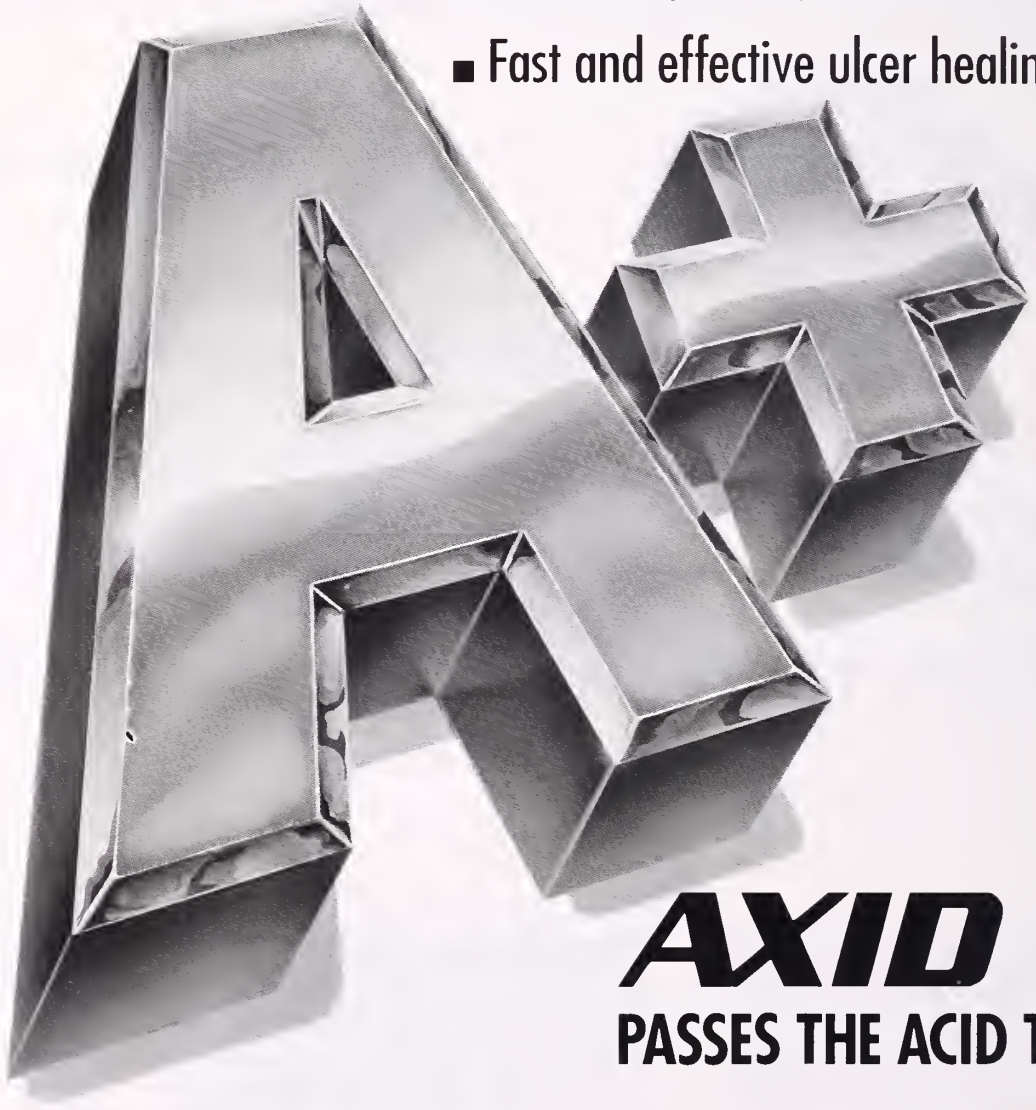
- Fast and effective ulcer healing[2,3,4]



AXID PASSES THE ACID TEST

*Most patients experience pain relief with the first dose.

See adjacent page for references and brief summary of prescribing information.

NZ-2943-B-149347

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AXID ® (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References
1. Data on file, Lilly Research Laboratories
2. *Scand J Gastroenterol* 1987,22(suppl 136):61-70
3. *Scand J Gastroenterol* 1987,22(suppl 136):47-55
4. *Am J Gastroenterol* 1989,84:769-774

NZ-2943-B-149347

Additional information available to the profession on request.

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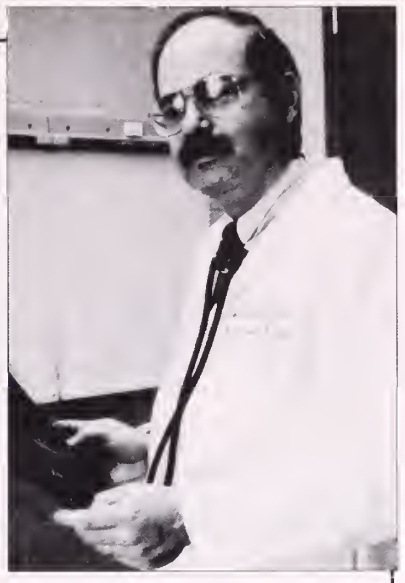

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Kathy says-
it's easier
when they've been gone awhile
the ultimate cold
narrows the diagnosis

I reply-
regardless
it is hard
and always too easy
for time is on my side

far from the pains
which brought this
silent shell
to this moment
the quiet peace of death

no heart tones
or spontaneous respiration
no response

pupils fixed
dilated
looking to God
in eternal contemplation

the abstraction of nothingness
and of all

my last note echoes
the final insignificance
of the intern's late night task.

–Jonathan Temte, MD
Madison❑

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Contestants:

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- Residents actively training in Wisconsin

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Rules:

- Subject matter must fall within the parameters of scientific medicine: clinical, case report, research and review
- Paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- Limited to 10 pages, typewritten, double-spaced, 1-inch margins
- Illustrations are encouraged, but must be included in the 10-page length limit
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority in all decisions

Criteria:

- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *Applicability:* usefulness of results to private practitioner, academician, researcher
- *Content:* depth of analysis, continuity of discussion supporting the main thesis, feasibility of conclusions
- *Innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, advancement of basic understanding
- *Organization*
- *Clarity of writing*

Deadline: Entries must be received by the *Wisconsin Medical Journal* no later than February 14, 1992: PO Box 1109, Madison, WI 53701

War and medicine in the desert
A report of the 13th Evacuation Hospital in Saudi Arabia

Guenther P. Pohlmann, MD, Milwaukee

On Nov 21, 1990, the 13th Evacuation Hospital from Madison was called to active duty to support the US Army's VII Corps, which had been sent to the Persian Gulf from Germany. Physicians, nurses, and other medical personnel from reserve components and the active army were attached to our unit to complement our personnel requirements. This report will provide an overview of our activities and experiences, and add some insight to the medical phase of the Persian Gulf conflict. The compilation of our clinical data was hampered by the frequent transfers of the patients and their medical records, as well as our lack of copying facilities. Inter-hospital communication and follow-up information were also deficient due to the constraints of preparation for the war. The assimilation of fragmentary reports, such as this one, into a comprehensive review of the lessons learned is currently taking place and should soon be available to the public. *Wis Med J* 1991;90(8):511-516.

THE HEALTH CARE DELIVERY SYSTEM of the US Army consists of two components: active duty, caring for active duty personnel, dependents and retirees; and the reserve (US Army Reserve and Army National Guard), which comprises 70% of the system's total personnel and which can be mobilized on short notice. Reserve medical units resemble their active duty counterparts in structure and function. They range from medical platoons with a staff of 40 to large station hospitals with 1,000 soldiers.

Since the cessation of the military draft, the army is entirely dependent on the reserves for reinforcement. This was reflected in their massive call-up during the Persian Gulf crisis. The 13th Evacuation Hospital, a unit of the Wisconsin Army National Guard, which was part of this reserve mobilization, is headquartered in Madison, has detachments in Chippewa Falls and Marshfield, and draws most of its personnel from those areas.

Called to active duty on Nov 21, 1990, the reservists of the 13th Evacuation Hospital spent 44 days at Ft McCoy in administrative processing, military training, and medical training, particularly in the care of chemical, biological, and nuclear warfare casualties. The unit arrived in Saudi Arabia on Jan 13, 1991, spent 10 days in a holding camp at Khobar and then proceeded, with its equipment, into the northern desert where the hospital and its equipment were assembled after all the components had arrived from the United States and Europe.

After the cease-fire, the hospital stopped all inpatient care on March 9, 1991. Its medical personnel was integrated with the 312th Evacuation Hospital. Some of our personnel prepared housing and equipment for the return to the United States.

The battlefield role

Medical care in a combat area is provided by individual medics who are assigned to combat and combat support units and by medical units which range from medical companies to large station hospitals (Table 1).

Previous military conflicts have taught us that the outcome of casualties is improved by the immediacy of their resuscitation, by rapid transport, and by the close availability of special

Dr Pohlmann holds the rank of colonel in the Medical Corps, Wisconsin Army National Guard and is with Columbia Hospital in Milwaukee. Reprint requests to: Guenther P. Pohlmann, MD, 2025 E Newport Ave, Milwaukee WI 53211. Copyright 1991 by the State Medical Society of Wisconsin.

resources. It is evident from Table 1 that the casualty progresses through these essential phases of care as it proceeds from level I through V. The proximity of a hospital or smaller medical units to the battlefield shortens distances and evacuation time for incoming casualties, and facilitates the return of the lightly wounded or ill to their military units.

In the absence of combat, the flow of the ill and injured through a field hospital resembles that of any community hospital (Fig 1). During combat, however, massive surges of casualties must be expected. This may be associated with a drop of regular admissions because of the forward deployment of military units in the area. In an evacuation hospital, the first surge represents direct admissions from the battlefield before the mobile field hospitals are able to establish their position near the front.

The second wave (Fig 1) consists of the transfers from these units after initial resuscitation and emergency surgery has been completed.

The third wave (Fig 1) consists of admissions and transfers of enemy prisoners of war (EPWs). Their care may have been delayed because of their capture and of the priority of caring for our own casualties.

A mass casualty situation exists when the need of incoming patients exceeds the available resources of a hospital. In that case, triage will establish for all incoming patients the priority for resuscitation and definitive care. In most field hospitals, the limited resources available for the care of a wide spectrum of illness and injury will result in a high transfer rate to other, more fully equipped hospitals. Our transfer to discharge ratio was 2:1.

Structure and staff

The evacuation hospital is a deployable medical system (DEPMED) assembled from transportable components and equipment. It can be set up in any suitable terrain and in most climatic zones. Prefabricated units (16' x 20' and 20' x 24') serve as operating rooms, laboratory, blood bank, X-ray, and pharmacy. Climate controlled tents (20' x 48') serve as intensive care and intermediate care wards, emergency rooms and ambulatory clinics. Large, general purpose tents (18' x 52') accommodate the slightly injured and ambulatory ill patients. A total of 400 beds are available, but occupancy is kept around 65% to ensure a supply of reserve beds for unexpected emergencies.

Diesel-powered generators supply

Table 1.–The flow of combat casualties through US Army medical care facilities.

	I. Combat Area	II. Battalion Aid Station (BAS)	III. Combat Support Hospital	IV. Evacuation Hospital	V. General Hospital
Care	Basic life support: Airway stabilization Spine immobilization Fluid resuscitation Pressure dressings Decontamination of NBC casualties	Advanced trauma life support Airway intubation Chest tubes	Emergency surgery Cessation of bleeding Initial debridement External fixation of fractures Burn care	Definitive and specialty surg. Further wound debridement Removal of all fragments	Long-term medical and surgical care Burn center Convalescence
Personnel	Buddy Aid Basic and advanced medical specialists (Emergency medical technicians and paramedics)	Same as I, plus Field surgeons and physician's assistants	Same as II, plus General surgeon Orthopaedist Anesthesiologist Nurses	Same as III, plus Thoracic surgeon Urologist Otolaryngologist Ophthalmologist Gynecologist Neurosurgeon Psychiatrist Radiologist	Same as IV, plus Physiatrist Pathologist
Average LOS	Less than 2 hours	Less than 24 hours	Less than 72 hours	Less than 7 days	Unlimited
Bed Capacity			200-300, mobile	300-400, fixed	800-1000, fixed

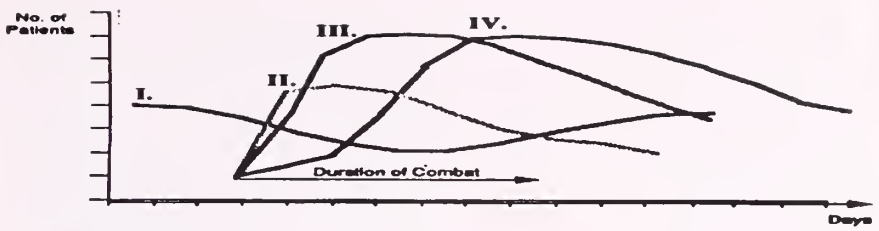
electricity for the hospital and the personnel tents. Water is trucked in and pumped to the various hospital stations. Our daily consumption of fuel was 1,500 gallons and of water, 4,000 gallons.

Oxygen was dispensed from individual cylinders, volume controlled ventilators and cardiac, arterial, and venous pressure monitors were available.

Laboratory tests were limited to CBC, urinalysis, blood urea nitrogen, blood glucose, sodium and potassium levels, gram stain and arterial blood gases because of a lack of reagents for other tests. The drug formulary was also restricted but adequate. X-ray studies were limited to plain films, upper and lower gastrointestinal and pyelographic contrast studies. The nearest mobile CT scanner was at another evacuation hospital, 60 miles away.

The 400 people working in our hospital had medical, administrative and technical functions (Table 2). Some held similar jobs in civilian life, but for many the military and civilian occupations digressed widely. For hospital occupancy of 65%, our staffing ratio was 2.9 FTE's per patient per day. which lies significantly below the 4.15 average for American community hospitals.[2] Our inpatient workload, however, never reached this level.

The commanding officer of any military hospital, akin to the CEO or administrator of a civilian hospital is always a physician. Department heads of medical and surgical specialties, nursing, support services, and administration are appointed as in civilian hospitals.



I. Routine flow of ill and injured (Community hospital function)
II. Direct admissions of combat casualties
III. Transfer admissions from mobile hospitals
IV. Wounded enemy prisoners of war (EPW)

Fig.—Patient flow in an evacuation hospital.

Even though all permanent military hospitals in the United States and abroad are subject to accreditation by the Joint Commission on Accreditation of Healthcare Organization, DEPMED hospitals are exempt. Formal quality assurance programs were suspended for the field hospitals of the Desert Shield and Desert Storm operations, but mortality and morbidity rates were monitored continuously.

There was no standard blood product use program. Because of supply shortages, we established guidelines for use of oxygen, antibiotics, and a few other medications. Biohazardous precautions followed US standards and practices, but a formal program of infection control could not be instituted because most laboratories lacked culturing capabilities.

Clinical experience

Some of the medical personnel participated in the staffing of primary care troop medical clinics before and after the operation of the hospital. At the Khobar holding area for recently arrived troops, respiratory infections and diarrhea had assumed epidemic proportions.

Bombardment of this area by Scud missiles necessitated that many hours were spent in gas masks and chemical protective suits, particularly at night. From this arose a "gas mask syndrome," consisting of claustrophobic panic states, dyspnea associated with the increased work of breathing, and the pyridostigmine side effects. This latter drug had to be taken as an antagonist to nerve gases, but its cholinergic action caused frequent headaches, orthostasis, nausea, vomiting, diarrhea, cough and wheezing. Tolerance of the gas mask effects was instilled by supervised wearing and physical exercise over progressively longer periods. Pyridostigmine doses were reduced, or their administration was extended from 6 to 8 or 12 hours to minimize the side effects.

Initially, some soldiers needed psychological counseling for the "mobilization stress syndrome." This condition consisted of anxiety and depression precipitated by the separation from family, home, and culture; the stress of associated economic hardships; and guilt over their voluntary enlistment in the military. Individual counseling helped these patients, but so did the bonding with other soldiers and the cohesiveness of their military units.

The author dedicates this report to the memory of William S. Middleton, MD, Col, MC, former dean of the Medical School of the University of Wisconsin. In the best tradition of our state, he dedicated his medical skills and knowledge to the care of our soldiers in both world wars and was influential in establishing the 135th Medical Regiment of the Wisconsin National Guard, as well as the 44th General Hospital of the US Army Reserve in Madison. The 13th Evacuation Hospital is the largest medical unit in the Wisconsin National Guard. It has continued the noble tradition of combat medical support which was provided during World War II by the 135th Medical Regiment for the Wisconsin National Guard's 32nd Division.[1]

Table 2.–Personnel of the evacuation hospital.

Physicians: 25 (Medical Corps)	
general surgeons	3
orthopaedists	4
thoracic surgeons	1
otolaryngologists	1
urologists	1
psychiatrists	1
ophthalmologists	1
gynecologists	1
anesthesiologists	1
internists	3
family practitioners	3
radiologists	1
dentists	1
Army Nursing Corps: 51	
nurse anesthetists	6
registered nurses	43
pharmacists	2
Administrative officers: 10	
commanding officiers (Medical Corps)	1
executive officer (Medical Service Corps)	1
personnel supply and patient administration officers	8
Enlisted Medical Personnel: 203	
practical nurses	78
Enlisted technical and administrative personnel: 110	
Total personnel: 402	

Once the hospital was established in the northern desert, and before the ground war started, we continued to be actively engaged in providing ambulatory care for some of the 36,000 soldiers stationed in our vicinity. Up to 200 soldiers were received daily in the emergency room, troop medical and orthopaedic clinics. The care of medical and surgical admissions prior to the arrival of combat casualties enabled us to consolidate the hospital as a system because the housing, the equipment, and the personnel had not been brought together before to take care of patients.

Respiratory infections and gastrointestinal disorders remained prevalent, but orthopaedic disorders of the back, ankles, shoulders, and knees soon became dominant because of the heavy physical work imposed upon the soldiers (Table 3). Gynecological problems were numerous among the outpatients because of the large number of female soldiers in the surrounding combat support units.

Prior to the ground war, we also received victims of the many motor vehicle accidents on the crowded northern highway and in the unfamiliar desert terrain.

The most common combat-related injuries were due to fragments from land mines, exploding tank armor, and artillery shells, which commonly affected the lower extremities, hands, and groin. Among the extremity injuries fractured bone, lacerated soft tissue, and vasculature often required simultaneous attention on the operating table. Only 17% of all combat injuries were due to rifle shots; they occurred predominantly among Iraqi prisoners and involved the chest and the abdomen. This war did not position soldier against soldier with rifles and bayonets. Its weapons were conventional but highly sophisticated and caused massive destruction.

A preliminary survey of all hospitals in our theater indicated that none of the endemic diseases of this area--such as brucellosis, leishmaniasis, hemorrhagic fevers, malaria, or schistosomiasis–had so far afflicted American soldiers.

Of the psychiatric disorders commonly seen among soldiers, the combat fatigue syndrome was observed in our hospital only in the Iraqi prisoners. American soldiers were not exposed to prolonged bombing, shelling, and the deprivation of water, food, and sleep, and therefore were able to avoid this distressing condition. Most of our psychiatric admissions were situational stress reactions without specific common denominators. Complaints of chest pains were rarely due to coronary artery disease, but admissions for pleuro-pericardial pain were more common.

As already noted, gynecological complaints predominated among the female ambulatory patients, but rarely required hospitalization. Only occasionally was an infectious etiology, manifested by fecal leucocytosis, found among the many patients with diarrhea.

Several interesting clinical conditions deserve to be mentioned here because of their distinct nature and relationship to the desert environment, military events, and general working conditions:

Desert dust asthma. This is a protracted asthmatic bronchitis with symptoms of dyspnea, cough and wheezing, clinical findings of inspiratory and expiratory wheezing, coarse rales, and expectoration of tenacious secretions. Spirometry showed mild to moderate airway obstruction, not improved by bronchodilator therapy but responsive to steroids. Some of these patients had pre-existing irritable airway disease. High concentrations of the fine desert dust and dryness appeared to contribute to this condition, and the use of face masks was recommended to all susceptible individuals.

Tank-crew anasarca. Some members of tank crews, who had spent many hours motionless in the upright position, developed dependent edema which extended as high as the face. Most of this occurred while driving through the desert at the onset of the ground war. Some of the soldiers were hypertensive, but none had proteinuria or clinical evidence of protein losing enteropathy. Their avid salt and water retention responded well to diuretic therapy.

Body bagger's flashbacks. Soldiers assigned the task of removing the bodies of dead allied and enemy soldiers often had to assemble and iden-

tify dismembered parts and deal with decomposition. Persistent memories of the odors and sights caused sleeplessness, nightmares, and panic states. Individual and group psychotherapy and mild tranquilizers improved the condition, however, long term sequelae must be anticipated.

Truck driver's back. The military version of this well-known civilian disorder was compounded by the stiff suspension and poor seat cushioning in large trucks that had to drive long distances over bumpy desert trails. Pain in the lumbo-sacral and midthoracic region was associated with muscle spasms and limitation of motion. Roentgenograms were unremarkable, but small stress fractures due to the vertically transmitted impacts could not be ruled out. Drivers were also required to wear 3.5 lb helmets at all times, which may have contributed to cervical spine irritation. Thrombosed hemorrhoids were also found more commonly in truck drivers.

EPW's esophagitis. A combination of stomatitis, esophagitis and gastritis in enemy prisoners of war (EPWs) occurred because of poor nutrition and obvious vitamin deficiencies. It responded to IV fluids, antacids, liquid diet, and vitamins. The fissuring and mucosal denudation visible in the mouth was probably due to vitamin B deficiencies.

Table 3.–Hospital admission diagnosis by organ systems for the 13th Evacuation Hospital, Feb 13, 1991, through March 9, 1991.

Organ system	# of admissions	% of total
musculoskeletal	114	26%
surgical procedures, including trauma	95	22%
gastrointestinal	35	8%
psychiatric	34	8%
respiratory	26	6%
cardiovascular	20	5%
ENT	12	3%
CNS (10), GU (11), GYN (9) infectious disease (8), metabolic (8)	46	10%
unknown	53	12%
Total	435	100%

Discussion

The war against Iraq demonstrated that after the cessation of the cold war, international consensus can rapidly be established empowering the United States and allied nations to engage an enemy with military force. The deployment of these troops may come unexpectedly and may involve distant regions of the world. For a military system to remain both effective and economical, large components have to be in the reserves, such as our unit, interdigitate with civilian skills and occupations, and yet be available for immediate activation.

In our search for lessons from this conflict, the following became apparent:

- Technical tasks were performed extremely well because monthly weekend drills, field exercises, and annual 15-day training courses had enabled us to practice the deployment of the hospital and put to use much of its equipment.
- Skills and knowledge related to and derived from the care of patients were more unevenly distributed and will in the future require more carefully structured training schedules and collaborative arrangements with civilian facilities.
- The military physician practicing in the field needs to be experienced in broader areas than the civilian job description ordinarily provides for.
- General surgeons require greater familiarity with operative orthopaedics because of the multiple injuries per casualty and the high incidence of extremity wounds. Internists have to be prepared to deliver primary care to a population of young men and women both beset with many orthopaedic problems and frequent gynecological complaints among the women. They have to be skilled in respiratory intensive care, including the use of the flexible bronchoscope, to manage patients in respiratory failure due to injuries (of which we had several) and due to chemical agents (of which, fortunately, we had none).
- Internists and family practitioners have to be prepared to assume the post-operative care of surgical patients when surgeons are continuously involved in the operating rooms.
- Nurses have to become familiar with the higher levels of intensive care which many combat casualties require.
- The rapid deployment of medical units and facilities into remote areas can be associated with significant supply problems. IV fluids, medications, laboratory reagents, X-ray film and developer were some of the items not available when our hospital became operational. The items in short supply differed from hospital to hospital. The physicians needed to improvise or to function without, otherwise shortages easily would have become "war stoppers." Careful monitoring of our

care of patients in the absence of some tests, specific drugs, or equipment so easily depended on in civilian practice revealed good outcomes, nevertheless.

The military bases in northern Saudi Arabia each extended over an area 20 miles in diameter and contained many combat support units, including several hospitals, because of the convenient access to water, fuel, and other essential supplies. Often, two evacuation hospitals were located next to each other but remained largely autonomous because of their organizational structures. As the patient load declined, the high operating costs demanded closure of hospital sections or entire hospitals and the consolidation of staff and patient care. This was readily accomplished, but it also reminded us that geographic, political, and strategic circumstances may, in the future, demand a more flexible and modular design of deployable fixed and mobile hospitals in a combat theatre.

Conclusion

The Desert Shield and Desert Storm military operations entailed the mobilization and overseas deployment of many active duty and reserve army medical units. This article presents the experience of one such field hospital unit, belonging to the Wisconsin National Guard. Eighty-five days of its mobilization were spent in preparation, 24 in operation, and 50 in demobilization and return to the United States. While in-patient care and surgical activities were limited to 24 days, ambulatory care of a large volume of soldiers was an ongoing task and challenge from the first to the last day.

The current distribution of US military medical resources between active duty and reserves will have to remain in place in the future. To assure optimal skills and performance of this reserve sector, upgraded collaboration between military and civilian training centers will be needed.

References

1. Becker, IM. William Shainline Middleton. *Wisconsin Medical Alumni Quarterly.* 1990.
2. *American Hospital Association Hospital Statistics.* 1990-1991. Chicago.❑

Hearing impairment and the elderly patient

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Hearing impairment is one of the most common causes of disability in the elderly. In addition to its obvious adverse effects on communication, hearing impairment has been associated with impaired mobility, cognitive impairment, and depression.[1] Treatment of hearing impairment can reduce symptoms of depression and improve quality of life in hearing impaired patients. Yet in the Framingham cohort, although 41% of those 65 years of age and older admitted to hearing difficulty, only 10% had ever used a hearing aid.[2] This article discusses the epidemiology of hearing problems in the elderly, types of hearing loss, the adverse effects of hearing loss, the benefits and drawbacks of hearing aids, and the role of the primary care physician in helping hearing impaired patients. *Wis Med J* 1991;90(8):516-519.

Hearing loss (whether conductive, sensorineural, or mixed) is established by audiometry. This examination typically involves three measurements: pure tone thresholds as heard through earphones (air conduction), pure tone thresholds via sound conduction through the skull (bone conduction), and the ability to understand words from a list at a comfortable listening level (speech discrimination). Pure tone thresholds are measured as a function of frequency and intensity. The pure tones are presented at different frequencies (500 cycles per second or Hertz [Hz], 1000, 2000, 3000, 4000, 6000 and sometimes 8000 Hz). Threshold is defined as the intensity, expressed in decibels (dB), at which a stimulus can be heard 50% of the time. The table shows the hearing levels which correspond to a given severity of hearing loss.[3]

There are four basic types of hearing loss: conductive, sensorineural and conductive, and central. Conductive losses are the result of middle ear disease or otosclerosis, and may be treatable by surgery, although surgical disease accounts for only 1% of elderly patients with hearing loss. A conductive loss is diagnosed when bone conduction thresholds are better than air conduction thresholds on an audiogram. In general, conductive losses are readily treatable by amplification, usually hearing aids. Cerumen impactions, however, can cause a noticeable conductive hearing impairment and should be removed

before performing any audiometric tests.

Sensorineural losses ("nerve deafness") result from defects in the cochlea or the auditory nerve, and are not amenable to surgical correction. Both bone conduction thresholds and air conduction thresholds are elevated in the sensorineural loss. Sensorineural hearing loss may be caused by exposure to sudden loud noises or to ototoxic medications and is usually bilateral. Traditionally, hearing aids have been felt to be less helpful in this kind of loss, but this view has changed in recent years. Unilateral hearing loss may be caused by noise exposure or infection, or rarely by an acoustic neuroma. The latter may require surgery to avoid further neurologic damage.

The most common type of hearing loss in the elderly is a form of sensorineural loss called presbycusis. It is characterized by loss of high frequency hearing (above 2000 Hz), decreased speech discrimination, and difficulty hearing in noisy environments. Onset is gradual, progressive and usually symmetrical. The cause of the disorder is controversial, but it is generally believed to result from the cumulative effects of lifetime noise exposure. Genetic factors also play a role. There is no surgical or pharmaceutical treatment, but patients often benefit from appropriate amplification.[4]

Central hearing loss is due to a defect in central auditory processing. It causes impaired understanding of speech beyond that expected from the patient's pure thresholds. As many as 50% of elderly hearing aid users may have some degree of central hearing loss.[5] It can coexist with other types of hearing loss, and occurs independently from cognitive impairment. It may impair the patient's ability to benefit from amplification, but does not preclude successful hearing aid use in a given patient.[5]

Epidemiology

The prevalence of hearing loss increases with age, whether self-report of hearing loss or audiometric measures are used. Using self-reported hearing impairment, men aged 65 to 70 in the Framingham cohort were found to have a rate of 41%, while men aged 85 to 90 reported rate of about 80%. Rates for women were slightly lower. Rates derived from audiometric measures were comparable.[2] The prevalence of hearing loss is higher in the nursing home population; estimates range from 50% to 100% depending on the criteria used to define hearing loss. Using a cut-off of 26 dB (pure tone average), the prevalence in a typical group of nursing home patients was 83%. Using a 40 dB cutoff, which may more accurately reflect hearing loss which interferes with activities of daily living, the prevalence was 48%.[6]

Hearing levels and degree of hearing impairment. (Adapted from Newby and Popelka, 1985.)

Hearing level	Degree of impairment	Benefit from aid
20-30 dB	slight	minimal
30-45 dB	mild	possible
45-60 dB	moderate	probable
60-75 dB	severe	probable
75-90 dB	profound	probable
90-110 dB	extreme	possible

Adverse effects in the elderly

It is well known that hearing impairment in early childhood can impair language acquisition and academic performance, but the effects of hearing loss in later life have been less well publicized. The effect of hearing impairment on a given individual will depend not only on the degree of hearing loss but also on personality factors, coping styles, and the quality of the patient's support system.

Hearing impairment can provoke negative reactions in other people. Hearing impaired persons may appear to be inattentive, stubborn, or mentally deficient.[1] They may appear to be unreliable because they did not hear what they were supposed to do. The elderly hard-of-hearing person may be inappropriately regarded as "senile." Constant requests for repetition can lead to resentment of the hearing-impaired individual, or to leaving him or her out of the conversation entirely. Hearing loss is also frustrating for the patient, who may find it easier to withdraw than to concentrate on trying to hear. This has important implications for the physician-patient relationship.

Perhaps, because of the above, hearing impairment has been associated with an increased incidence of depression and of social isolation.[1,7] Hearing-impaired elderly persons are less mobile, even after accounting for other chronic health problems, and are at greater risk of falling.[8] This may be due to a lack of clues from the environment. There is also evidence that hearing loss is associated with cognitive impairment. Uhlmann, et al found that the prevalence of hearing loss was higher in Alzheimer's disease patients than in age-matched controls. Patients with more severe

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hearing loss were more likely to have dementia.[9] This finding is not solely attributable to difficulty in hearing the instructions for the mental status exam;[10] however, whether hearing loss plays a causative role in dementia, or vice-versa, is uncertain.

Hearing aids

Hearing aids can improve the quality of life of elderly persons with hearing loss. In a study of 194 veterans, those who received hearing aids were compared to those on a waiting list at 6 weeks and 16 weeks. The hearing aid recipients showed improvement in scores of social and emotional function, communication function, cognitive function, and depression, while those on the waiting list showed no significant change.[12]

Hearing aids are used in many different situations. They are most helpful in understanding speech, listening to television, music or movies, in church, in meetings or at other public events. They can also be helpful in warning of environmental hazards.[13]

There are circumstances in which hearing aids do not meet patients' expectations. Patients with hearing aids often have trouble understanding speech when background noise is present. Patients with very severe impairments may derive only modest benefit from a hearing aid, although it may give them sufficient information to improve communication. Some patients have difficulty handling the miniature controls due to arthritic fingers; some hearing aids have remote control devices to overcome this problem. Patients who have difficulty with their earmolds (discomfort while wearing the aid or excessive feedback) should bring these problems to the attention of their hearing aid specialist. Many times these problems can be corrected.

Hearing aid specialists are crucial in selecting the appropriate aids for the patients, training them to use the aids and providing counseling regarding realistic expectations of hearing aid capabilities. Adjustment to a new hearing aid can take days to months, depending on the user. Patients who are not motivated to use their aids are less likely to become successful users. Lack of motivation may stem from a belief that they do not need a hearing aid or a perception that it is not helping them.[14]

On important obstacle to hearing aid use is cost. Hearing aids are not covered by Medicare or by most private insurance plans. A single hearing aid can cost from several hundred dollars to $1,000, depending on the model and where it is purchased. Patients should be aware that there is a 30-day trial period during which they can return the hearing aid if it is not satisfactory.

Other listening devices

Devices other than hearing aids are also useful for hearing-impaired persons. Personal amplifiers may be helpful in listening to another speaker or to the television. Battery-powered amplifiers for telephones can be purchased from telephone or electronics stores and are easy to install and remove. Some public telephones have built in amplifier switches. For those who are unable to hear on the telephone, Telephone Devices for the Deaf (TDD) telephones are an option, although they can be used only to call another TDD telephone. Many churches have listening devices for those who request them; convention centers, theaters and concert halls may have them as well.

Hearing impairment and physicians

Hearing impairment can have a negative effect on the doctor-patient relationship. Taking histories may be difficult, and patients may fail to understand their diagnosis or recommendations for treatment. Physicians may find themselves talking to patients' family members rather than to the patient. Patients' satisfaction can be impaired if they feel ignored or do not understand what health professionals are saying.

How can physicians help hard-of-hearing patients in their practices? Several techniques can improve communication.

First, environmental factors are important. Background noise should be minimized. Turn off the television, close the door, seek privacy. Light should shine on the speaker's face rather than coming from behind him. The speaker should sit or stand at the patient's eye level. Face hearing-impaired persons when speaking–it is impossible to read lips if they cannot see the speaker's lips. Mustaches, gum chewing, or a hand held in front of the face can also interfere with lip reading.

Second, encourage patients to wear their hearing aids to the office or in the hospital. A personal amplification device such as a pocket talker may be helpful for those who do not have aids.

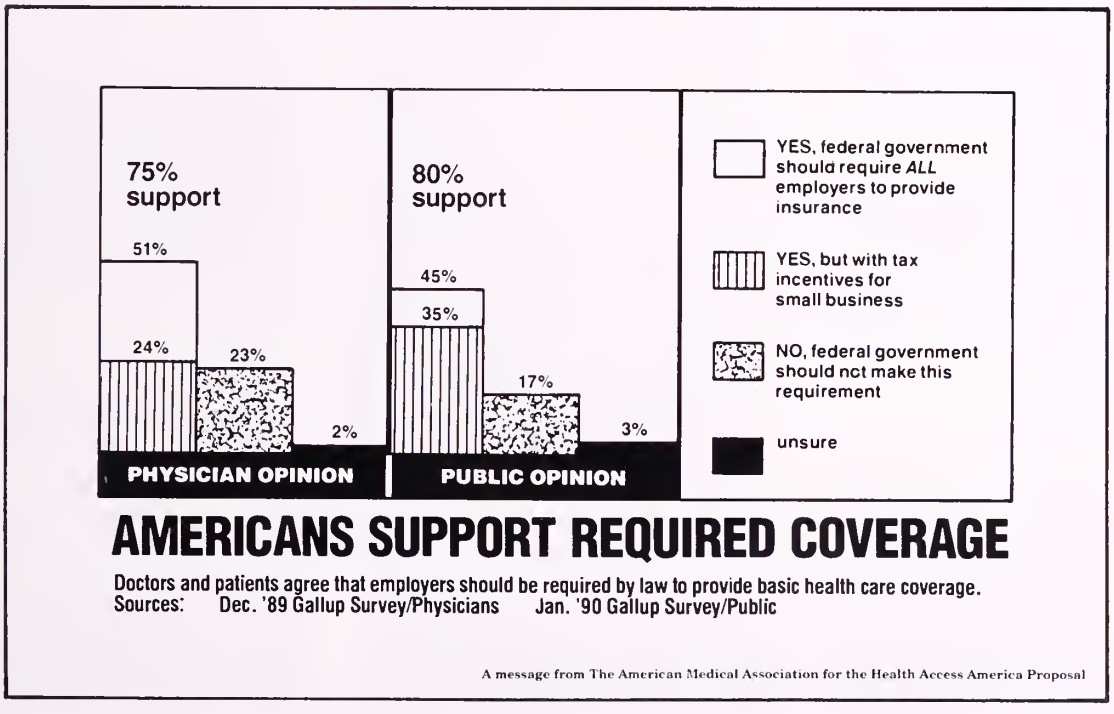
Third, use good communication skills. Be sure the patient knows that someone is speaking to him or her. It helps if the person knows the topic; he or she can then use contextual clues to understand the speaker. When possible, speak clearly and distinctly rather than shouting. If a particular word or phrase is hard to understand, rephrase the sentence. If necessary, use gestures or write the words down. Speak simply, in short sentences. Even people with normal hearing have trouble understanding medical terms. Ask the patient to let the speaker know if he or she does not understand what was said. If there is doubt, ask him or her to repeat it.[15] Finally, if his or her hearing has not been evaluated, refer the patient for an audiologic examination.

Unfortunately, may physicians do not routinely refer their elderly patients for hearing evaluations.[16] It is unclear whether this is because physicians do not view hearing impairment as an important medical problem or because patients do not bring it to their physicians' attention. The

high prevalence of hearing loss in this population, however, and the potential benefits of amplification imply that screening efforts would be beneficial. This may be done by using a short questionnaire, such as the Hearing Handicap Inventory for the Elderly, in addition to or instead of a hand-held screening instrument such as the Audioscope®.[17,18] Otolaryngologic referral can rule out correctable causes of hearing loss, while audiologic referral will assess the patient's need for a hearing aid.

References

1. Herbst KG. Psychosocial consequences of disorders of hearing in the elderly. In: Hinchcliffe R, ed. *Hearing and Balance in the Elderly.* New York, NY: Churchill Livingstone. 1983.
2. Gates GA, Cooper JC, Kannel WB, et al. *Hearing in the Elderly: The Framingham Cohort.* 1983-1985. Basic Audiotromic Test Results. *Ear and Hearing* 1990;11(4):247-256.
3. Newby HA, Popelka GR. *Audiology.* 5th ed. Englewood Cliffs, NJ: Prentice-Hall, Inc. 1985: ch 10.
4. Olsen WO. Presbycusis: When hearing wanes, is amplification the answer? *Postgraduate Medicine.* 1984;76(3): 189-195.
5. Kricos PB, Lesner SA, Sandridge SA, et al. Perceived benefits of amplification as a function of central auditory status in the elderly. *Ear and Hearing.* 1987;8(6):337-342.
6. Schow R, Nerbonne MA. Hearing levels among elderly nursing home residents. *Journal of Speech and Hearing Disorders.* 1980;45:124-132.
7. Magilvy JK. Quality of life of hearing-impaired older women. *Nursing Research.* 1985;34(3):140-144.
8. Tinetti ME, Speechley M. Prevention of falls among the elderly. *N Eng J Med.* 1989;320(16):1055-1059.
9. Uhlmann RF, Larson EB, Rees TS, et al. Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. *JAMA.* 1989;251(13):1916-1919.
10. Uhlmann RF, Teri L, Rees TS, et al. Impact of mild to moderate hearing loss on mental status testing: Comparability of standard and written Mini-Mental State Examination. *Journals of the American Geriatric Societies.* 1989;37:223-228.
11. Ohta RJ, Carlin MF, Harmon BM. Auditory acuity and performance on the mental status questionnaire in the elderly. *Journal of the American Geriatrics Society.* 1981;29(20):476-478.
12. Mulrow CD, Aguilar C, Endicott JE, et al. Quality-of-life changes and hearing impairment: A randomized trial. *Ann Int Med.* 1990;113:188-194.
13. Niederkorn J, Block E, May J, et al. A study on hearing aid satisfaction. Dept of Audiology, Clement J. Zablocki Veterans Administration Medical Center. Milwaukee, Wisc, Unpublished data, 1988.
14. Surr RK, Schuchman GI, Montgomery AA. Factors influencing use of hearing aids. *Arch Otolaryngol.* 1978;104:732-736.
15. Kennedy MK. Will you help me? *SHHH! (Self-Help for Hard of Hearing People).* 1986;Nov/Dec:6-7.
16. Logan SA, Ahlstrom J, Bess FH. Identification and referral of hearing-impaired elderly by primary car physicians. Presented at American-Speech-Language-Hearing Association Convention, Washington, DC. 1985.
17. Weinstein BE. Validity of a screening protocol for identifying elderly people with hearing problems. *American Speech and Hearing Association.* 1986;May:41-45.
18. Frank T, Petersen DR. Accuracy of a dB HL Audioscope® and audiometer screening for adults. *Ear and Hearing.* 1987;8(3):180-183.❑



Characteristics of alcohol use by school children in a northcentral Wisconsin county

Willard E. Pierce; Steven K. Broste, MS; and Peter M. Layde, MSc, MD, Marshfield

Before a school-based substance abuse prevention program was introduced, students in grades 5 through 12 in a northcentral Wisconsin county completed a questionnaire on their experience with tobacco, alcohol, and other drugs. Alcohol abuse was widespread, even among the youngest students surveyed. Commencement of alcohol use in the 5th grade or earlier appears to be increasing in recent years. There was a dose response relationship observed between the amount of alcohol consumed and the reported frequency of poor grades, thoughts and attempts of suicide, driving after drinking, remorse, and memory loss. Physicians caring for adolescents need to consider the possible role of alcohol abuse in a number of clinical situations. Because of their unique expertise and stature in the community, physicians also have an important role in community-oriented substance abuse prevention programs. *Wis Med J* 1991;90(8):520-524.

According to both alcohol sales data and self-reports of alcohol consumption, Wisconsin residents are among the heaviest consumers of intoxicating beverages in the United States.[1] In addition to overall consumption, Wisconsin has among the highest rates of binge drinking (defined as more than five drinks at a time) and driving after drinking in the country.[1] Other studies provide supporting evidence that there are severe alcohol abuse problems in the state.[2,3]

The past decade has seen an increased concern by physicians and public health officials about alcohol use in adolescents.[4-6] The health consequences of excessive alcohol consumption are well known, but not always recognized.[7] Alcohol intoxication is the most important risk factor for motor vehicle fatalities,[8] and chronic alcohol abuse increases the risk of cirrhosis; numerous cancers, including head and neck, esophageal, gastric, colon, pancreatic, and liver; as well as many other serious problems.[5,9] The psychologic effects of alcohol abuse on individuals and families is also well known.[10] Drinking in adolescents is of particular concern both for its immediate hazards, such as automobile injuries, and for its association with alcohol abuse and morbidity in later life.[4,11]

The schools in this northcentral Wisconsin county are in the process of introducing an extensive alcohol and other drug prevention program to their schools and community. This program includes an expansion of the existing alcohol and other drug curriculum for grades K through 12, core group training of school staff, addition of trained alcohol and other drug abuse counselors, development of awareness groups such as Students Against Drunk Driving (SADD), establishment of a student assistance program, instituting the Quest (Skills for Adolescents) and Drug Abuse Resistance Education (DARE) programs, along with public awareness programs addressed to the community. Nationally known speakers and other programs will be presented to parents and students.

Local school officials wished to establish baseline information that would allow for subsequent comparisons to determine the effectiveness of their program in deterring the use of alcohol and other drugs, and solicited assistance in survey methods from the Department of Epidemiology and Biostatistics of the Marshfield Medical Research Foundation. The survey afforded the opportunity to study in detail the characteristics of alcohol and other drug use in an entire population of students, grades 5 through 12, in a rural Wisconsin county.

Methods

This county, located in northcentral Wisconsin, is a fairly typical rural Wisconsin county. It has a population of 18,900 with a population density of 19.4 per square mile.[2] The population center and county seat has a population of fewer than 5,000. Most of the population resides in rural areas or small villages. Farming, forestry, and manufacturing of wood and food products are the primary industries. The median income for 1986 was $14,217 per household.

A self-administered questionnaire was given on Dec 20, 1989, to all students in grades 5-12 in this county. Five schools were involved. One school was an elementary school with only grade 5 participating, and one school was a middle school with

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grades 5 and 6. The three other schools contained students in grades 5 through 12. To avoid contamination, the survey was administered on the same day to all schools and at the same time in each school.

The survey instrument contained questions on the following: family description, adult supervision after school, academic grades achieved, extracurricular activities, thoughts of and attempts at suicides, driving while intoxicated, and extent, frequency and age of first use of alcohol and other drugs.

A total of 1,920 survey forms were completed. The number of students in each grade ranged from 223 in grade 8 to 293 in grade 9. Prior to computer entry of these data, each form was reviewed for inconsistency or factitious responses. Thirteen of the 1,920 questionnaires (0.1%) were excluded for various reasons: refusal to answer (1); incomplete with less than 60% of the questions answered (3); all responses checked (3); obvious factitious answers, such as indicating maximum daily use of all drugs (4); vulgar comments and own answers added (2).

A survey for experience with alcohol and other drugs from a sample of 6th, 8th, 10th, and 12th grade students in Wisconsin was conducted in 1988 by the Department of Public Instruction and the Search Institute.[13] Data from that survey are used for comparison with this survey's data, both with respect to current alcohol usage and to age at onset of alcohol use.

Results

By the 5th and 6th grades, the majority of students had tried alcohol at least once in their lives. Among students in grades 11 and 12, nearly 90% of them had tried alcohol. Particularly among the younger students, some of this use of alcohol consisted solely of having tasted sips of alcohol on a few occasions in their lives. Our subsequent analyses focus on alcohol use in the month prior to the administration of the questionnaire.

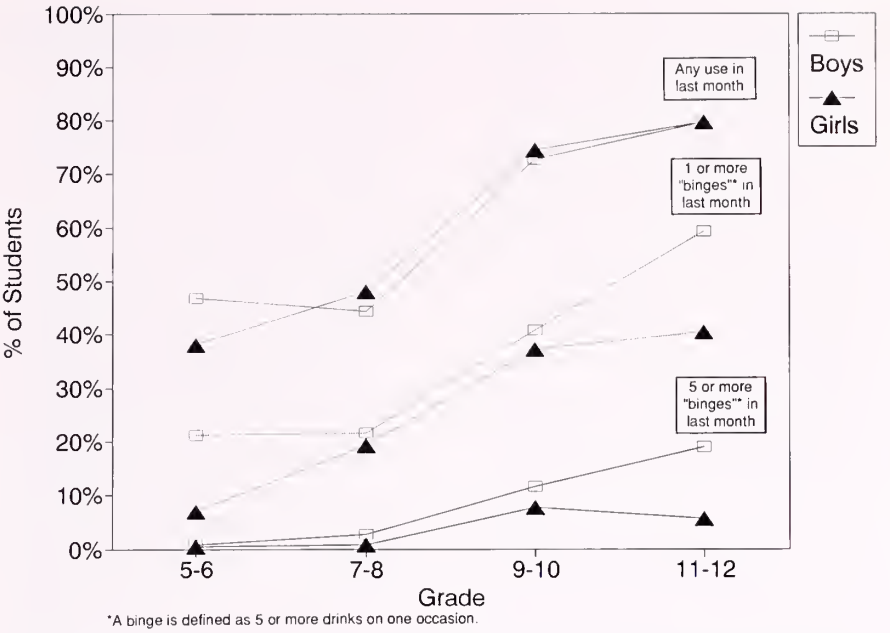

Fig 1.–Percent of students using alcohol in the last month, by grade, sex, and amount.

Figure 1 shows the percent of boys and girls in different grades who reported drinking alcohol in the previous month. The proportion of students drinking any alcohol in the past month ranged from a low of 38% among girls in grades 5 and 6 to a high of 80% among both boys and girls in grades 11 and 12. Frequent drinking was prevalent. Of boys in grades 7 and 8, 9.3% reported using alcohol more than five times in the past month (not shown). For junior and senior boys, the percent using alcohol more than five times in the past month increased to 41.4%. Beyond the frequency of alcohol use,

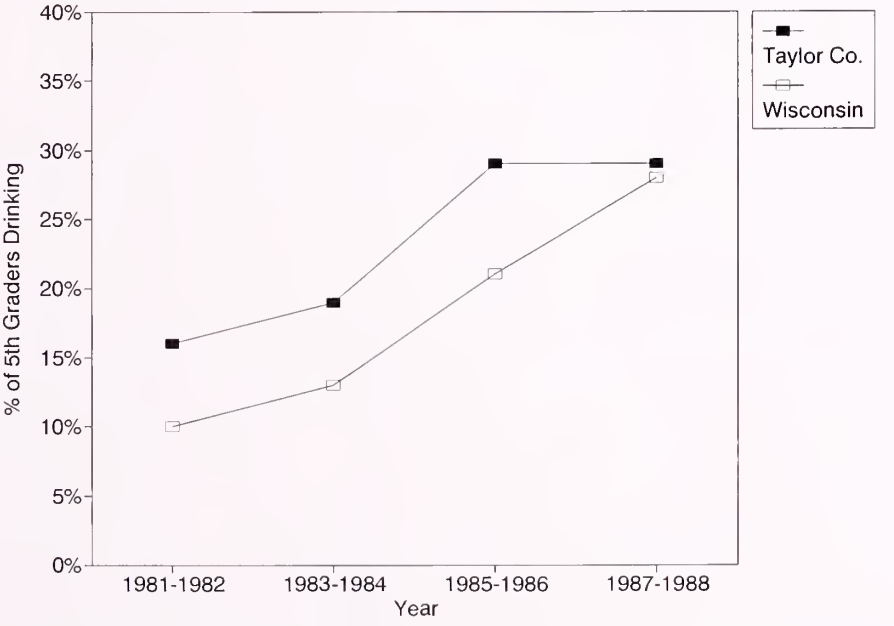

Fig 2.–First use of alcohol in grade 5 or before, in a northcentral Wisconsin county and the state.

the high proportion of binge drinking (five drinks or more on one occasion) was also noteworthy (Fig 1). More than 20% of boys in grades 5 and 6 reported at least one binge drinking episode in the previous month, while almost 60% of the junior and senior boys reported that level of heavy drinking. Binge drinking on more than five occasions in the previous month was less frequent but was reported by 12% of freshman and sophomore boys and 19% of junior and senior boys. Binge drinking on five or more occasions was reported appreciably less often by girls than by boys.

There is evidence from a survey of students in Wisconsin conducted in 1988[13] and from our 1989 survey of this county that students started to use alcohol at progressively earlier ages throughout the 1980s (Fig 2). Current 6th graders are much more likely than the current 12th graders to report having used alcohol in the 5th grade or earlier.

Table 1 indicates that a number of sources provided alcohol to students. In the lower grades, most students obtained alcohol either directly from their parents, or by surreptitiously taking it from their parents' supply. While this remained a frequent source for high school students, older friends were the most common source of alcohol in that age group. Also of note, very few students use false identification, yet a sizable percentage of students reports obtaining alcohol from retail establishments or taverns.

In Table 2, various characteristics of high school juniors and seniors are shown according to the students' reported use of alcohol in the past month. There are a number of differences between heavy drinkers (with at least one binge of five or more drinks in the past month), light drinkers (drinking in the last month, but with no binges), and those reporting not drinking in the past month. Fewer heavy drinkers reported receiving grades of A or B, participating in extracurricular activities at school, or dealing easily with stress at home. On the other hand, more drinkers reported feeling sad and hopeless at least sometime in the past month, having had serious thoughts about hurting themselves in a way that could cause their death, or having actually tried to hurt themselves in a serious way. Drinkers also reported increased frequencies of riding with a driver who had used drugs or alcohol, and driving themselves after having had too much to drink. The majority of heavy drinkers reported having done something while drinking that was later regretted, and drinking to the point of not being able to remember everything that had happened. Heavy drinkers reported consistently higher rates of use of cigarettes and illegal drugs than their light and nondrinking counterparts. There was an inverse relationship between drinking level and perception of there being a problem with alcohol in their area.

Discussion

Before discussing the implications of the results of this study it is worth considering potential limitations to the data. Because this questionnaire was administered to virtually all students in the county, it is really a cen-

Table 1.–Percent of students in a northcentral Wisconsin county who drink alcohol who obtain alcohol from each source, by grade and sex.

Source	Current grade							
	5-6		7-8		9-10		11-12	
	Boys (n=73)	Girls (n=28)	Boys (n=84)	Girls (n=81)	Boys (n=151)	Girls (n=162)	Boys (n=166)	Girls (n=133)
Parents buy	23.3	28.6	17.9	22.2	32.5	35.8	30.7	36.8
Take from parents' supply	38.4	57.1	51.2	48.1	43.7	50.6	31.3	26.3
Older friends	13.7	7.1	31.0	46.9	56.3	61.7	81.9	69.9
Use of false ID	1.4	0.0	3.6	2.5	4.0	1.2	7.2	0.0
Grocery store	2.7	0.0	7.1	2.5	9.9	9.3	11.4	6.8
Convenience mart	0.0	0.0	4.8	2.5	14.6	6.8	22.9	10.5
Liquor store	2.7	0.0	7.1	1.2	8.6	8.0	16.3	7.5
Tavern	15.1	14.3	23.8	22.2	34.4	22.2	53.0	39.1

sus rather than a survey—there is no statistical variability to the results. Rather, the biggest question about the data, particularly considering the high levels of self-reported alcohol use, is whether the students were exaggerating their experience with alcohol. While no definitive proof is available on the point, there are several lines of evidence suggesting that the students in our survey did not overestimate their alcohol consumption.

First, other studies indicate that self-reporting surveys underestimate alcohol and other drug use.[1] For example, based on sales records, the average Wisconsin resident purchased 3.19 gallons of alcohol during 1985, but Wisconsin residents interviewed during the same period estimated that they consumed the equivalent of only 1.02 gallons of alcohol. Second, the high level of alcohol use among school children is consistent with data indicating unusually high levels of drinking among other groups in Wisconsin.[2,3] Finally, when these data were presented to the adult members of this community no questions were raised about their accuracy. When the audience was asked directly if these data were plausible, they responded with many stories of young children being intoxicated.

The results of this survey are worrisome. They indicate a high level of alcohol abuse among school children in a rural Wisconsin county. Alcohol abuse starts at an early age, appears to be getting worse in recent years, and is associated with many dysfunctional academic and psychosocial behaviors.

The greatest increase in the use of alcohol occurred during the 7th and 8th grade. This was most true among the girls, who reported considerably less experience in grades 5 and 6 than boys, but by grades 9 and 10 had experience with alcohol equal to or greater than the boys. Binge drinking, that is more than five drinks at a time or drinking weekly, was reported more frequently by boys than by girls, particularly in grades 11 and 12.

The trend of earlier use of alcohol in recent years by Wisconsin and this county's students is alarming. While memory may pay a role in defining when alcohol was first used, this was not apparent in data on the first use of cigarettes or other drugs. Future studies should be designed to define carefully the onset and the extent of alcohol abuse.

Alcohol use in this county's students is greater than that reported for the rest of the state. Eighty-two percent of this county's 12th grade students reported having used alcohol in the past month compared to the state's experience of 62%. Moreover, in the past month 55% of this county's seniors reported having five or more

Table 2.–Percent of high school juniors and seniors in a northcentral Wisconsin county reporting various characteristics, by use of alcohol in past month.

	None (n=87)	Never more than 5 drinks/occasion (n=130)	5 or more drinks at least once (n=213)
Percent male	54.0	38.3	63.8
Mostly A's or B's in school	59.8	61.5	40.4
At least some extracurricular activity	81.6	81.5	74.5
Easy to deal with stress at home	47.1	26.2	32.9
Sad and hopeless at least sometimes in past month	40.2	53.8	61.5
Ever seriously thought about hurting self in way that could cause death	17.4	29.5	34.6
Ever actually tried to hurt self in way that could cause death	2.3	11.6	14.6
In past month, rode with driver who used drugs or alcohol before driving	23.0	42.3	81.2
In past month, drove after too much to drink	0.0	3.9	38.9
Spend more than $5/week on alcohol or drugs	1.1	3.1	21.9
In past year, did something after drinking that was regretted	9.2	24.8	59.5
In past year, drank to point of not remembering everything that happened	8.0	17.1	61.2
Smoked cigarettes in past month	6.9	26.4	55.7
Used illegal drugs in past month	1.1	1.5	8.9
Think there is an alcohol problem in area	81.6	71.5	53.6

drinks on one occasion compared to 37% for the state. This degree of heavy use of alcohol is alarming and is of particular importance in a rural area. The automobile is the primary mode of transportation for high school students and great distances are often travelled to attend social or athletic events. Forty-eight percent of this county's seniors had ridden in the past month with a driver who had too much to drink. Further, during the same period, 26.5% of seniors had driven a car after drinking too much.

These data reveal that, in addition to the well known costs of chronic alcohol abuse to health care and society in general,[8,14,15] there may be other hidden costs of such abuse to students in this county. Driving after drinking, poor grades, suicidal thoughts and attempts, remorse, and memory loss after drinking are among the other negative events associated with drinking in these students.

The association of heavy drinking with other substance abuse is also of concern and we are analyzing our data on this subject in more detail. Physicians must be aware when encountering many different conditions that the underlying cause may be an alcohol or other drug abuse problem even in very young students.

Older friends and parents were the two greatest sources of alcohol for these underaged students in this county. The role of parents in procuring alcohol is particularly disturbing. In the early grades the students take from their parents' supply, but parents apparently buy for their children at all grade levels. These data suggest that an effective alcohol abuse prevention program must include parents. Since retail establishments and taverns are also a major source of alcohol for these students, and since false identification is used infrequently, law enforcement officials should also be involved in such programs.

Because of their expertise on health matters and their frequent role as community leaders, physicians, and other health care professionals have an important role in alcohol abuse prevention programs.[16] Broad community coalitions composed of teachers, police, merchants, youth organization leaders, and students themselves, as well as physicians, may be particularly useful in reducing alcohol abuse in students.[17] Surveys like that described in this report may be useful both in heightening community awareness of the problem and in providing baseline and follow-up data useful in evaluating the effectiveness of interventions.[17]

Acknowledgement

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References

1. Smith PF, Remington PL, Williamson DF, et al: A comparison of alcohol sales data with survey data on self-reported alcohol use in 21 states. *Am J Public Health* 1990;80:309-312.
2. Centers for Disease Control. Alcohol related disease impact—Wisconsin, 1988. MMWR 1990;39:178-180,185-187.
3. Wisconsin Department of Health and Social Services, Office of Alcohol and Other Drug Abuse: Alcohol and other drug abuse indicators, July 1989.
4. Kandel DB, Logan JA. Patterns of drug use from adolescence to young adulthood: I. Periods of risk for initiation, continued use, and discontinuation. *Am J Public Health* 1984;74:660-666.
5. Niven RG. Alcoholism–a problem in perspective. *JAMA* 1984;12(14):1912-1914.
6. Schwartz RH, Hayden GF, Getson PR, et al. Drinking patterns and social consequences: a study of middle-class adolescents in two private pediatric practices. *Pediatrics* 1986;77(2):139-143.
7. Moore RD, Bone LR, Geller G, et al. Prevalence, detection, and treatment of alcoholism in hospitalized patients. *JAMA* 1989;261(3):403-407.
8. Zylman RA. A critical evaluation of the literature on 'alcohol involvement' in highway deaths. *Accid Anal Prev* 1974;6:163-204.
9. Eckardt MJ, Harford TC, Kaelber CT, et al. Health hazards associated with alcohol consumption. *JAMA* 1981; 246(6):648-666.
10. Vaillant GE. The natural history of alcoholism. Cambridge: Harvard University Press, 1983.
11. Brown RC, Sanders JM, Schonberg SK. Driving safety and adolescent behavior. *Pediatrics* 1986;77(4):603-607.
12. Welte JW, Barnes GM. Alcohol: the gateway to other drug use among secondary-school students. *J Youth Adolesc* 1985;14(6):487-498.
13. Wisconsin Department of Public Instruction: The Wisconsin study: alcohol and other drug use. A Search Institute Report, April 1989.
14. Peterson DE, Akguliau NA, Remington PL: Alcohol-related disease in Wisconsin, 1988. *Wis Med J* 1990;89:232-234,236.
15. Manning WG, Keeler EB, Newhouse JP, et al: The taxes of sin: do smokers and drinkers pay their way? *JAMA* 1989;261:1604-1609.
16. Bowen OR. Raising public awareness about the extent of alcohol-related problems: an overview. *Public Health Rep* 1988;103(6):559-563.
17. Pentz MA, Dwyer JH, MacKinnon DP, et al. A multicommunity trial for primary prevention of adolescent drug abuse. *JAMA* 1989;261(22):3259-3266.

Severe illness associated with group A-hemolytic streptococcal infections

Jay C. Butler, MD; Benjamin Schwartz, MD; Judy Kimball; and Jeffrey P. Davis, MD; Atlanta and Madison

The Wisconsin Division of Health (DOH) began surveillance for severe illnesses associated with group A beta-hemolytic streptococcus (GABS) infections in late 1989 to describe the current epidemiologic features and clinical spectrum of these infections in the state. Severe illness was defined by the isolation of GABS from the blood or by the development of one or more of the following in a patient infected with GABS: shock, extensive tissue injury, desquamating rash, disseminated intravascular coagulation, renal failure, adult respiratory distress syndrome, or death. Case reports involving 28 patients with severe GABS-related illnesses with onset from November 1989 through October 1990 were received by the DOH. The majority of the case-patients had sepsis (57%), cellulitis (50%) or both. Nine (32%) cases were fatal. Those who died were older than those who survived (median age 74 years v 43 years, p = 0.002) and were more likely to have clinical diagnoses that included pneumonia (relative risk [RR] 3.0, 95% confidence interval [CI] 1.2, 7.3) or necrotizing fasciitis/myositis (RR 3.7, 95% CI 1.5, 9.0). The median interval from illness onset to hospitalization was similar for fatal cases (1 day) and non-fatal cases (2 days), suggesting that early intervention after the appearance of clinical illness may not improve the outcome. *Wis Med J* 1991;90(8):525-529.

Recent reports have raised concern that bacteremia and severe illness associated with group A beta-hemolytic streptococcal (GABS) infections may have become more prevalent during the past decade.[1-5] The Wisconsin Division of Health (DOH) established surveillance for severe illness associated with GABS infections in December 1989. In this article, we summarize epidemiologic, clinical, and laboratory data from 28 reported cases of severe illness associated with GABS infection occurring between November 1989 and October 1990.

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Methods

Two articles in the Wisconsin Epidemiology Bulletin requested health professionals to report to the DOH (by telephone or in writing) cases of severe illness associated with GABS infection.[6,7] A case of severe illness associated with GABS infection was defined by the isolation of GABS from blood or by the development of shock, extensive tissue injury, desquamating rash, disseminated intravascular coagulation (DIC), renal failure, adult respiratory distress syndrome (ARDS), or death in a patient infected with GABS. Cases with reported symptom onset occurring between Nov 1, 1989, and Oct 31, 1990, are included in this summary. A standardized case abstraction form developed at the Respiratory Diseases Branch, Division of Mycotic and Bacterial Diseases (DMBD), Centers for Disease Control (CDC) was sent to the reporting agency or person. Case abstraction was completed by telephone interview of the reporting physician for all patients for whom the initial form was not returned.

Personnel in microbiology laboratories in which the GABS were isolated were contacted by telephone, and when possible, the respective isolates were sent to the Bacterial Reference Laboratory, DMBD, CDC in Atlanta through the State Laboratory of Hygiene (SLH) for serotyping.

Identification of group A streptococci was confirmed by colony morphology, beta-hemolysis on blood agar, and capillary precipitin testing of Lancefield extracts with group-specific antiserum. Isolates were characterized by M-type and T-type with the use of capillary precipitin and slide agglutination testing, respectively. Typing sera were prepared at CDC and tested using reference strains. Since antisera for all M and T proteins are not available, strains designated "non-typable" constitute a heterogeneous group and should not be considered as a single type.

The Poisson probability distribution test for clustering of events in time was used to compare numbers of expected and observed events. Testing for statistical significance used the chi-square test and two-tailed Fisher exact test for dichotomous

variables and the Kruskal-Wallis test for continuous variables. Taylor series confidence intervals were calculated for relative risks.

Results

The reported cases represent a rate of 0.6 cases per 100,000 persons per year in the general population of Wisconsin (1990 population estimate, Wisconsin Department of Administration). The mean case-patient age was 47.2 years (1 standard deviation 25.4 years; range 6 to 89 years). While symptom onset occurred during all months of the study period, 14 (50%) cases-patients had symptom onset during January through April; however, if 9.3 cases are expected during each four month period assuming a random distribution of cases in time, time clustering was not statistically significant (Poisson p = 0.09) (Fig 1).

Each case-patient was hospitalized for evaluation and treatment, and 10 (36%) case-patients were hospitalized on the day of symptom onset. Sepsis, cellulitis, or both were the most frequent clinical diagnoses at presentation (Table 1). Reported signs and symptoms included fever (≥100°F) in 25 (89%) cases, hypotension (systolic blood pressure ≤90 mm Hg) in 13 (46%), syncope or orthostatic hypotension in 7 (25%), myalgia in 6 (21%), and generalized rash in 5 (18%). Four patients (14%) developed clinical symptoms of toxic shock syndrome (TSS) with hypotension, multiple organ involvement, and generalized rash followed by desquamation.[8] Three of the four case-patients with TSS-like illness were younger than 10 years old.

Underlying medical conditions were present in 17 (61%) case-patients, and included intercurrent acute varicella infection in 3 (11%) patients, cancer in 3 (11%), diabetes mellitus in 2 (7%), congestive heart failure in 2 (7%), history of recent trauma in 2 (7%), history of recent surgery in 2 (7%), and immunosuppressive therapy in 2 (7%).

Reported complications included renal impairment in 7 (25%) patients, DIC in 4 (14%), and ARDS in 3 (11%). Myotomy or amputation to remove necrotic tissue was performed in 3 (11%) cases. Nine (32%) patients died. The median age of case-patients who died was 74 years, compared to 43 years for case-patients who survived (p = 0.002) (Fig 2). The outcome was not associated with race or gender. Case-patients whose clinical diagnosis included pneumonia or necrotizing fasciitis/myositis were at greater risk of death than case-patients who did not have one or both of these conditions. For case-patients with the clinical diagnosis of pneumonia, the relative risk (RR) of a fatal outcome was 3.0 (95% confidence interval [CI] 1.2, 7.3), compared to those who were not

Table 1.—Clinical diagnoses at presentation and outcome for 28 patients with invasive group A beta-hemolytic streptococcal infections, Wisconsin, 1989-90. Some patients had more than one clinical diagnosis.

Clinical Diagnosis	No. Cases (% of total)	No. Died (CFR#)
sepsis	16 (57)	5 (0.31)
cellulitis	14 (50)	6 (0.43)
pharyngitis	6 (21)	1 (0.17)
necrotizing fasciitis/myositis	5 (18)	4 (0.80)
pneumonia	4 (14)	3 (0.75)
meningitis	3 (11)	1 (0.33)
endometritis/post-partum sepsis	2 (7)	0
post-surgical wound infection	2 (7)	0
non-surgical wound infection	1 (4)	0
spontaneous bacterial peritonitis	1 (4)	0
septic arthritis	1 (4)	0
osteomyelitis	1 (4)	0
cervical adenitis	1 (4)	0

CFR = Case-fatality ratio for clinical diagnosis

Table 2.—Frequency of isolate serotype and clinical outcome for 20 cases of invasive group A streptococcal infections, Wisconsin, 1989-1990.

Serotype	Outcome # died	Outcome # survived	total (%)
M-1	1	3	4 (20)
M-3	1	1	2 (10)
M-4	1	0	1 (5)
M-12	0	1	1 (5)
M-18	0	1	1 (5)
M non-typable:			
T-1	1	0	1 (5)
T-2	1	2	3 (15)
T-3	0	1	1 (5)
T-14	0	1	1 (5)
T non-typable	1	4	5 (25)

diagnosed with pneumonia. The RR of death for case-patients with necrotizing fasciitis/myositis was 3.7 (95% CI 1.5, 9.0) compared to those without this condition. The median interval from symptom onset to death was 4 days (range 1 to 87 days). The median interval from reported symptom onset to hospitalization in cases resulting in death was similar to that of cases not resulting in death (1.0 versus 2.0 days, p = 0.9). The case-fatality ratio (CFR) among case-patients with reported underlying medical conditions (6/17, 0.35) was similar to the CFR among case-patients without underlying conditions (3/10, 0.30).

GABS was isolated from the blood in 26 (93%) case-patients, from abscess fluid in 4 (14%), from cerebrospinal fluid in 3 (11%), and from synovial fluid, peritoneal fluid, and urine in 1 (4%) case-patient each. Each patient with a fatal outcome had a positive blood culture. GABS was also isolated from a non-sterile site in 7 (25%) patients: pharyngeal swab, three patients; wound, 2 patients; and sputum, 2 patients. The results of negative cultures from non-sterile sites were not reported. Only one case-patient did not have GABS isolated from a normally sterile site. Isolates from 20 patients were serotyped; 19 of the isolates were from normally sterile body sites and one was from the throat of a case-patient with TSS-like illness. Five isolates (25%) were M and T non-typable. No serotype was associated with more than one death (Table 2).

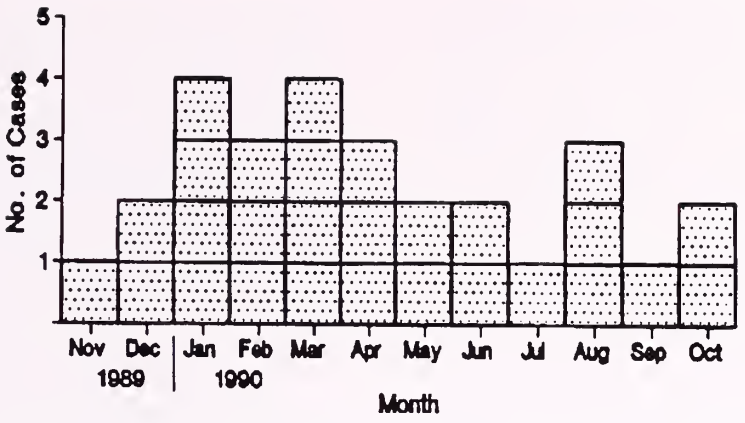

Fig 1.–Month of symptom onset in 28 cases of severe illness associated with group A beta-hemolytic streptococcal infection in Wisconsin, 1989-1990.

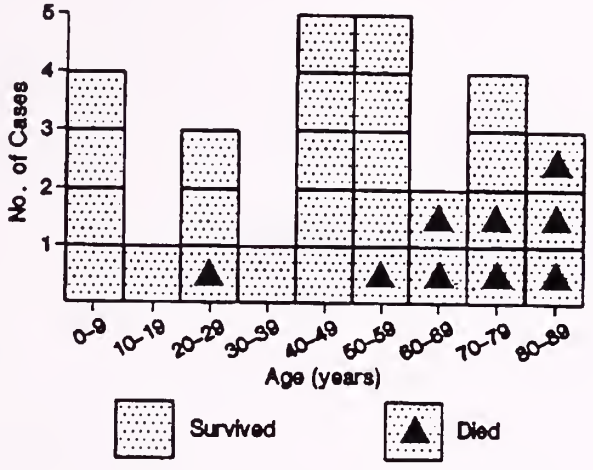

Fig 2.–Age and outcome for 28 case-patients with severe illness associated with group A beta-hemolytic streptococcal infection in Wisconsin, 1989-1990.

Discussion

The observed rate of 0.6 cases of severe illness associated with GABS infections per 100,000 persons per year in this report is considerably less than invasive GABS infection rates determined by retrospective reviews of clinical microbiology laboratory records of 7/100,000/year in metropolitan Denver and 4.3/100,000/year in Pima County, Ariz.[4,9] This difference is at least partially due to active case-finding in the Colorado and Arizona studies, while case-finding was probably less complete with the passive system of case-reporting used in Wisconsin. Moreover, the observed case-fatality ratio (CFR) of 0.32 is greater than the CFR of 0.20 in the Arizona study;[9] this may represent the greater tendency to report cases involving a death.

Delay in hospitalization was not associated with a fatal outcome among patients with severe illness associated with GABS infection in Wisconsin. The patients who died generally had a fulminant course with death occurring less than a week after symptom onset despite seeking medical care within a day of becoming ill. The lack of association between the length of the interval from illness onset to hospitalization and outcome suggests that early evaluation and treatment may not reduce mortality due to severe illness associated with GABS infections.

Risk factors for death among patients in this series included advanced age and a clinical diagnosis of necrotizing fasciitis/myositis or pneu-

monia. These findings were not unexpected. Mortality among bacteremic persons 60 years old or older is 40%-60% regardless of the organism involved,[10] and necrotizing fasciitis/myositis is frequently caused by GABS and associated mortality is as high as 73%.[11,12]

The association of varicella with invasive GABS infections has been observed previously.[13-15] Among children with GABS bacteremia, 12%-24% have associated varicella infection.[16,17] The association between varicella and GABS bacteremia most likely lies in the disruption of the integument allowing organisms on the skin to penetrate to underlying tissues and the bloodstream.

Currently, it is not entirely clear whether there has been an increase in the incidence of GABS bacteremia or a change in the spectrum of clinical illness caused by GABS infections. In the Pima County, Ariz, report there was no change in the incidence of invasive GABS infections between January 1987 and March 1990; however, the incidence of TSS-like illness associated with invasive GABS infections had increased significantly since 1985.[9] Changes in the clinical spectrum of GABS disease could be due to emergence of toxin-producing strains or due to changes in serotype distribution. From their study of 10 GABS isolates from patients with TSS-like illness, Stevens, et al, concluded that more virulent, pyrogenic exotoxin A-producing strains have appeared.[1]

The proportion of GABS isolates from normally sterile body sites is greater for serotype M-1 and M-3 isolates compared to other serotypes, and the proportion of serotype M-1 isolates have increased significantly during the 1980s in the United States and Great Britain.[18,19] The M protein has anti-phagocytic properties and is an important virulence factor.[20] Among the cases of serious illness associated with GABS infections in Wisconsin, 6 of 19 (32%) of the isolates from normally sterile body fluids were either serotype M-1 or M-3.

Clusters of invasive GABS infections occurring among residents of nursing homes and a recent report of transmission of GABS-associated TSS-like illness from a patient to an emergency medical technician during cardiopulmonary resuscitation emphasize the need for further research into methods of limiting transmission of GABS infections.[21,22] The role of microbiologic surveys and chemoprophylaxis in limiting spread of GABS infections is yet to be defined. During institutional outbreaks of GABS infections, however, screening of asymptomatic persons for

Continued on next page

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GABS infection with cultures of the throat and any skin lesions followed by institution of antimicrobial therapy may be considered.[21] Anti-streptococcal therapy should be initiated when cultures are obtained; after culture results are available, a full 10-day course of therapy is indicated only for those with cultures positive for GABS. Penicillin is the recommended drug for GABS infections; erythromycin is a suitable alternative for penicillin allergic persons.[23] Isolating patients with GABS infections until after 24 hours of effective antibiotic treatment is recommended.[24] Fortunately, despite concern about increasing severity of GABS infections, the organism remains universally sensitive to penicillin, and resistance to erythromycin is rare.[23]

References

1. Stevens DL, Tanner MH, Winship J, et al. Severe group A streptococcal infections associated with a toxic shock-like syndrome and scarlet fever toxin A. *N Eng J Med* 1989;321:1-7.
2. Cone LA, Woodard DR, Schlievert PM, et al. Clinical and bacteriologic observations of a toxic shock-like syndrome due to *Streptococcus pyogenes*. *N Eng J Med* 1987;317:146-149.
3. Bartter T, Dascal A, Carroll K, et al. Toxic strep syndrome: A manifestation of group A streptococcal infection. *Arch Intern Med* 1988;148:1421-1424.
4. Centers for Disease Control. Group A beta-hemolytic streptococcal bacteremia—Colorado, 1989. *MMWR* 1990;39:3-11.
5. Lentnek AL, Giger O, O'Rourke EO. Group A ß-hemolytic streptococcal bacteremia and intravenous substance abuse: A growing clinical problem? *Arch Intern Med* 1990;150:89-93.
6. Wisconsin Division of Health. Severe streptococcal disease. *Wis Epidemiol Bull* 1989;11(4):8.
7. Wisconsin Division of Health. Severe disease due to group A beta-hemolytic streptococci. *Wis Epidemiol Bull* 1990;12(1):1-2.
8. Centers for Disease Control. Case definitions for public health surveillance. *MMWR* 1990;39(RR-13):38-39.
9. Hoge C, Schwartz B, Porter B, et al. Population-based study of invasive group A streptococcal infections. Presented at: 30th Annual Interscience Conference on Antimicrobial Agents and Chemotherapy, Atlanta, GA, Oct 21-24, 1990. Abstract #506.
10. McGowan JE. Community-acquired bacteremia. In: Gleckman RA, Gantz NM, eds. Infections in the Elderly. Boston: Little, Brown and Co, 1983;207-215.
11. Strasberg SM, Silver MS. Hemolytic streptococcal gangrene: An uncommon but frequently fatal infection in the antibiotic era. *Am J Surg* 1968;115:763-768.
12. Rouse TM, Malangoni MA, Schulte WJ. Necrotizing fasciitis: A preventable disaster. *Surgery* 1982;92:765-770.
13. Bradley JS, Schlievert PM, Sample TG. Streptococcal toxic shock-like syndrome as a complication of varicella. *Pediatr Infect Dis J* 1991;10:77-79.
14. Bullowa JGM, Wishik SM. Complications of varicella: Their occurrence in 2534 patients. *Am J Dis Child* 1935;49:923-926.
15. Smith EWP, Garson A, Boyleston JA, et al. Varicella gangrenosa due to group A beta-hemolytic *Streptococcus*. *Pediatrics* 1976;57:306-310.
16. Wong VK, Wright HT. Group A-hemolytic streptococci as a cause of bacteremia in children. *Am J Dis Child* 1988;142:831-833.
17. Christie CDC, Havens PL, Shapiro ED. Bacteremia with group A streptococci in childhood. *Am J Dis Child* 1988;142:559-561.
18. Schwartz B, Facklam R, Breiman R. Changing epidemiology of group A streptococcal infection in the USA. *Lancet* 1990;336:1167-1171.
19. Gaworzewska E, Cloman G. Changes in the pattern of infection caused by Streptococcus pyogenes. *Epidemiol Infect* 1988;100:257-269.
20. Quinn RW. Streptococcal infections. In: Evans AS, Feldman HA, eds. Bacterial Infections of Humans: Epidemiology and Control. New York: Plenum, 1982;525-552.
21. Centers for Disease Control. Nursing home outbreaks of invasive group A streptococcal infections—Illinois, Kansas, North Carolina, and Texas. *MMWR* 1990;39:577-579.
22. Valenzuela TD, Hooten TM, Kaplan EL, et al. Transmission of "toxic strep" syndrome from an infected child to a firefighter during CPR. *Ann Emerg Med* 1991;20:90-92.
23. Kaplan EL, Wannamaker LW. Group A streptococcal infections. In: Feigin RD, Cherry JD, eds. Textbook of Infectious Diseases in Children. 2nd ed. Philadelphia: W.B. Saunders, 1987;1312-1322.
24. American Public Health Association. Streptococcal diseases caused by group A (beta-hemolytic) streptococci. In: Benenson AS, ed. Control of Communicable Diseases in Man. 15th ed. Washington: American Public Health Association, 1990 411-417.□

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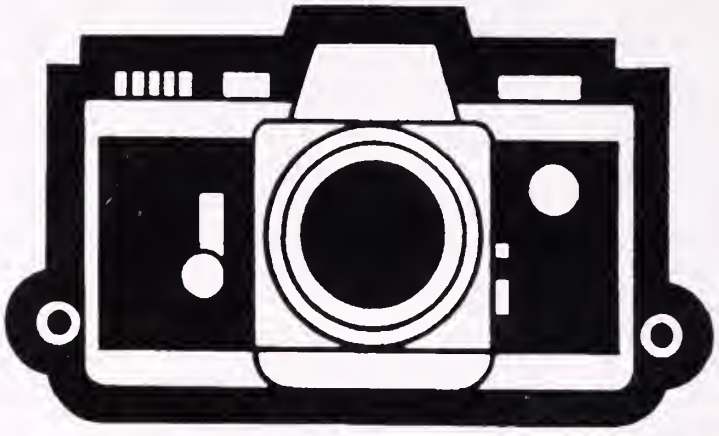

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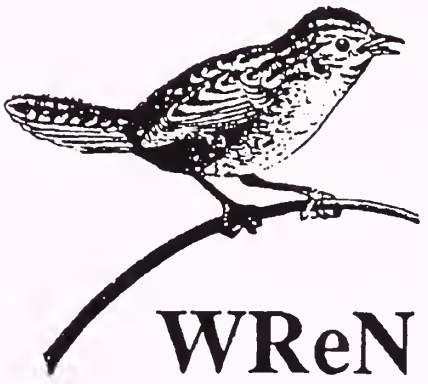
Development and operation of the Wisconsin Research Network

John W. Beasley, MD; Narra Smith Cox, PhD; Barbara Tenor Livingston, MPA; James E. Davis, MS, MD; Patrick McBride, MD; Terry L. Hankey, MD; Richard Shropshire, MD; and Richard G. Roberts, MD, JD, Madison

In 1987, the Wisconsin Academy of Family Physicians developed the Wisconsin Research Network (WReN) to support practice-based primary care research throughout Wisconsin. WReN has three objectives: to support the research efforts of individual physicians in community practices, to facilitate collaborative research among practicing physicians, and to provide academically based investigators with access to community practice sites. Due to a policy of actively encouraging membership, WReN has grown to 460 members during its 4-year history. Five WReN-supported papers have been published, and 22 state and national level presentations of WReN-supported research results have been made. Competitive grants totaling more than $2 million have been awarded to university-based investigators for studies using the resources of WReN. This paper describes the development, organization, and success of WReN as well as the challenges which must be addressed. *Wis Med J* 1991;90(8):531-537.



In 1987, the Wisconsin Academy of Family Physicians (WAFP) directed its research committee to build an organization to support research among WAFP members. Given this directive, the WAFP Research Committee created the Wisconsin Research Network (WReN) and became the WReN steering committee. Thus, WReN exists as a project of the WAFP. The first annual WReN meeting was held in the fall of 1987.

At that time, the goal of WReN was to support practice-based research in Wisconsin. The related objectives were: to support the research efforts of individual physicians in community practices, to facilitate collaborative research among practicing physicians and to provide academically based investigators with access to community practice sites.

At the time of its formation, WReN was offered an opportunity to facilitate physician participation in a study approved by the National Cancer Institute (NCI). Unfortunately, the study was approved, but not funded. Nonetheless, even without external funding, the WReN steering committee approved participation in the cancer screening study to demonstrate the feasibility of conducting research within WReN and to provide a focal point for member participation.

The experience with the initial cancer screening study proved that WReN could participate effectively in formal studies. Twenty physicians and 272 patients participated.[1,2] At the same time, a separate study testing a measure of continuity of care in physicians' practices was undertaken with 23 physicians and 423 patients participating. Once it became evident that WReN had progressed from the stage of an intriguing idea to the stage of a new and functioning research network, financial challenges emerged.

Continued on next page

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Continued from preceding page

Developmental issues

The issue of organizing WReN was related to the broader goal of facilitating research by WAFP members. Therefore, in addition to WReN, the WAFP developed two other programs to enhance the research efforts of WAFP members. The WAFP Research Stimulation Grant Program made available small amounts of research funding to WAFP members. The Summer Research Externship Program was established to fund one student from each of the two Wisconsin medical schools during the summer to collaborate on a project with a community-based physician and with an academically based physician. Funding was necessary for WReN and these two additional programs.

Initial support for these three related programs was provided by the Wisconsin Institute of Family Medicine (WIFM), the philanthropic arm of the WAFP. At that time it was believed that funds generated by WReN participation in the funded studies of established researchers would provide major financial support for the WReN infrastructure (eg staff salaries, newsletter publication, database development and maintenance), as well as limited funding to support individual physician projects and network-wide projects of special interest to WReN members.

Funding to support the development of the infrastructure of WReN, however, was difficult to obtain. Outside project-related funding could not be obtained until the network had a track record, yet it was difficult to develop a track record without outside start-up funding. The survival of WReN for the first 3 years was made possible by the support of WIFM, the WAFP, the SMS Charitable, Educational and Scientific Foundation, pharmaceutical companies, WAFP members who made personal contributions and in-kind contributions from the University of Wisconsin Medical School Department of Family Medicine and Practice.

It was 2 years after its formation before WReN was able to get financial support for a project. Funding from the Merck, Sharp and Dohme company was obtained to study the effectiveness of an educational program related to heart disease prevention. Most of this funding was needed to cover expenses incurred as part of the project and minimal excess funds remained to support the WReN infrastructure. In view of the difficulty in obtaining financial support to cover the base operational expenses, WReN implemented the concept of an access fee for the use of WReN resources. This concept parallels the manner in which an organization might pay for the services of any outside laboratory or service agency.

WReN's base budget expenses, exclusive of University of Wisconsin and other in-kind contributions, have been approximately $45,000 per year. This figure is slightly less than the typical annual research network start-up figure of $50,000.[3] Support from WIFM and from the WAFP, where $25 of each member's dues go toward WReN, has been critically important in maintaining WReN. Nonetheless, the funding of the basic administrative infrastructure remains a continuing problem.

Features of WReN

Several elements are necessary for a network to be successful. One formal discussion of these is found in a review article by Green and Lutz.[3] These include an organizer who has credibility with the involved organizations and their constituencies. In the case of WReN, the initial organizer was a physician in an academic setting who was able to arrange for protected time to facilitate the network development and who had ready access to secretarial and related support services.

To provide an initial focus for the network activities there has to be one or more projects which are of interest to the members. For WReN this focus was provided by early studies of patient continuity and cancer screening behavior.[1,2]

There must be one or more sponsoring organizations who are willing to provide initial and continuing support, both political and financial. These sponsoring bodies must have input into the governance of the network. Most importantly, representatives of the membership at large must have substantial say in developing the directions of the network. The WAFP is the primary sponsoring organization for WReN and has full control of the network. The WReN steering committee is a committee of WAFP members and includes both members in private practice settings and members who represent the two Wisconsin medical schools. It meets approximately four times a year, most often by telephone. The WReN steering committee provides general direction for WReN, decides which projects will be undertaken, provides planning input for the annual meeting and allocates research stimulation grant monies.

To maintain member interest and awareness, symbols and communications are important. WReN's logo is recognizable to its members and others. A regular newsletter, an annual report and an annual meeting facilitate communications. The newsletter contains, from time to time, an interactive insert that provides an easy method of obtaining member comments and suggestions, and of updating the membership database. A computer bulletin board service for WReN members was established with the support of the University of Wisconsin Medical School, the SMS Charitable, Educational and Scientific Foundation, and a private corporate donation.

Physicians and others participating in network activities need to receive some benefits from membership. These advantages can include attendance at the annual meeting, access to research funding, recognition, and whatever other "perks" can be developed. Academically based re-

Continued on page 534

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Continued from page 532
searchers get salaries, staff support, equipment, prestige, and other benefits. Physicians in private practice who are conducting or participating in research deserve comparable rewards.

Paid staff is essential if the network is to manage its affairs effectively. Since its inception, WReN has had a part time masters or doctoral level coordinator. The coordinator is currently employed 75% time and is provided with secretarial support.

Funding is a critical problem at all phases of network development. A "Catch 22" exists for starting networks. Generally, funding is available only for experienced investigators conducting specific clinical projects; it is very difficult to find funding to support the development of the infrastructure that will allow the initial growth and operation of the network. In the case of WReN, a physician organization (the WAFP and its 501[c]3 affiliate, WIFM) and the University of Wisconsin (UW) provided start-up funding as well as continuing support. In addition, research networks need a long-term financial commitment for sustaining support so they are not entirely dependent on project-based grant funding. The current approach of requiring researchers wanting to use WReN resources (access to physicians and assistance with the design and implementation of studies) to contract with WReN may provide a mechanism for some long-term funding.

An additional feature of WReN is the identification of a non-physician contact person within the office of each participating physician. Designated as "WReN site coordinators," these office staff members facilitate communication between the WReN office and the participating physician. The original concept of the site coordinator arose from the need to conduct chart reviews for a study. Without explicit patient consent, ethical concerns made it problematic for outside auditors to review private clinic charts. Ethical problems were avoided by training non-physician clinic employees to audit charts within the practice. While problems of inter-rater reliability have limited the use of WReN site coordinators as chart reviewers, WReN is beginning to use the enthusiasm and skills of these individuals to help maintain effective administrative contact with the practices.

Finally, WReN has had a policy of a low entry threshold for potential members. Physicians with any interest in research are encouraged to join WReN. Unlike some networks which require the development of an age and sex registry, WReN membership brings no special obligations. Physicians in specialties other than family practice are welcome, as are residents and medical students.

Accomplishments to date

In one sense, the most important accomplishment of WReN has been to grow and develop as a functioning and productive entity. WReN has grown rapidly in its 4-year history. Membership now totals 460 members in 62 of the 72 counties in Wisconsin. Perhaps more significantly, WReN has met its goal of facilitating primary care research in Wisconsin. WReN has provided technical support for individual members, recruited physicians and their practices for six formal studies, and provided an annual forum for the presentation of reports of the research conducted by individual members as well as reports of network research.

To date, WReN has facilitated the publication of five papers. These have included the work of a single practice correlating maternal birthing positions and perineal injury,[4] pilot work on early intervention in alcoholism,[5,6] a study of the implementation of a systematic health maintenance protocol,[7] and an exploratory study of the determinants of mammography screening.[1,2] There are four additional papers in preparation.

Activities supported by WReN have resulted in four papers presented at the national level, 18 papers presented at the state level, and the placement of eight Summer Research Externs (medical or premedical students) placed with community-based physicians.

Current WReN projects include an evaluation of a program of heart disease prevention education, the Primary Care Prevention Project, a trial of early intervention in the treatment of alcoholism, and participation in a National Heart, Lung, and Blood Institute sponsored study of digoxin use and mortality.

WReN has enhanced the ability of Wisconsin's academic institutions to compete for federal and private research grants. During 1989 and 1990, grants totaling $2.1 million were awarded to Wisconsin academic medical centers for projects using WReN resources. WIFM has received an additional grant of $30,500 for a Heart Disease Prevention Education Evaluation Project conducted by WReN.

Continuing challenges

While the progress of WReN has been excellent, major problems remain. The first is WReN's inability to reward its members appropriately for their time and efforts. Other than personal satisfaction, the only rewards are small WAFP Research Stimulation grants, the availability of summer research externs, and a reduced registration fee for the WReN annual meeting. These incentives are minimal when compared with those available to academically based researchers.

A related challenge is the need for WReN to be responsive to the research interests of its membership, especially those in private practice. For the most part, WReN has been occupied mainly with large funded projects of academically based investigators rather than conducting projects reflecting the collective research interests of its members.

Finally, WReN continues to have

problems achieving stable financial support for its base administrative structure, including salary support for the director. This problem could become critical if WReN should lose any of its current support sources. Most funding received by WIFM for WReN has been earmarked for specific project expenses; insufficient amounts remain to cover basic operational expenses.

Discussion

During its 4-year history, WReN has become a viable and productive primary care research network. WReN is a replicable model of a partnership of an academic medical center, community-based physicians and their professional organizations. WReN provides support both for research originating within the academic medical center and for the research interests of practicing physicians. WReN owes its success to many factors and particularly to the support of the individual WReN members and their office staff members who have been willing to donate their time and energies to conducting practice-based research.

As recognition of the need for practice-based research increases, the creation and success of research networks such as WReN will depend on corporate, governmental and private funding. With this support, research networks can provide new and valuable knowledge which will improve the practice of primary care.

Acknowledgements

The authors gratefully acknowledge support of the active WReN members whose names appear at the end of this article. We further recognize the expert assistance of Mary Stone in her support of WReN and the preparation of this manuscript. In addition to the supporting organizations noted within the text, we acknowledge the computer equipment donation by Service Electronics Corporation of Verona, Wisc.

References

1. Love RR, Davis JE. Screening mammography in clinical practice: A complex activity. *Arch Intern Med* 1991;151:19-20.
2. Davis JE, Meyer DL, Love RR. Cancer prevention activities in primary care group practice: physician estimates, physician performance, and practice structure. *Prev Med* (accepted for publication, 1991).
3. Green LA, Lutz LJ. Notions about networks: Primary care practices in pursuit of improved primary care. In Primary Care Research: An Agenda for the 90s, conference proceedings. Washington, DC: Agency for Health Care Policy Research; 1990.
4. Olson R, Olson C, Smith Cox N. Maternal birthing positions and perineal injury. *J Fam Pract* 1990;30:553-557.
5. Fleming MF, Brune M, Barry KL, et al. Informed consent, deception, and the use of disguised alcohol questionnaires. *Am J Drug Abuse* 1989;15:309-319.
6. Barry KL, Fleming MF. Computerized administration of alcoholism screening test in a primary care setting. *Am J Board Fam Pract* 1990;3:93-98.
7. Hahn DL, Berger MG. Implementation of a systematic health maintenance protocol in a private practice. *J Fam Pract* 1990;31:492-504.

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Public health

Breast cancer in Wisconsin: the potential for primary prevention

Paula M. Lantz, MA, and Patrick L. Remington, MD, Madison

BREAST CANCER is the most common cancer and the leading cause of cancer death among Wisconsin women. This year, approximately 3,000 Wisconsin women will be diagnosed with breast cancer and 900 women will die from the disease. Previous reports in this series have discussed the potential for decreasing breast cancer mortality through early detection. In contrast, the purpose of this report is to assess the potential for actually reducing the incidence of breast cancer.

Prior research has suggested that genetic differences do not account for the discrepancy in breast cancer incidence rates found among different countries.[1] Therefore, international variation in breast cancer incidence is most likely due to differences in lifestyle or other environmental factors. We estimate the potential to decrease the incidence in breast cancer by comparing Wisconsin incidence rates with those of the United States and other industrialized nations. Breast cancer incidence (as well as mortality) rates have been highest in North America and Northern Europe, intermediate in southern Europe and Latin America, and lowest in Asia and Africa.[2] We compare Wisconsin incidence with one country representing the intermediate level (Yugoslavia) and one country representing the lowest level (Japan), as well as with the United States as a whole.

Data on breast cancer incidence were gathered from three sources. For all populations under study, age-specific rates (for 5-year age groups ranging from 20-24 years to 85+ years) were estimated as the average incidence for a 4-year period. Wisconsin incidence data were obtained from the Wisconsin Cancer Reporting System for the years 1979-1982. National incidence data were taken from the National Cancer Institute's Surveillance, Epidemiology and End Results registry for the years 1978-1981.[3] The Japanese data are from Miyagi Prefecture and the Yugoslavia data are from Slovenia, both for the years 1978-1981 as published by the International Agency for Research on Cancer and the International Association of Cancer Registries.[4] Since the use of mammography for the early detection of breast cancer has contributed to recent increases in the reporting of cases in both the United States and in Wisconsin, we chose to use data from a time period which predates the widespread use of mammographic screening.

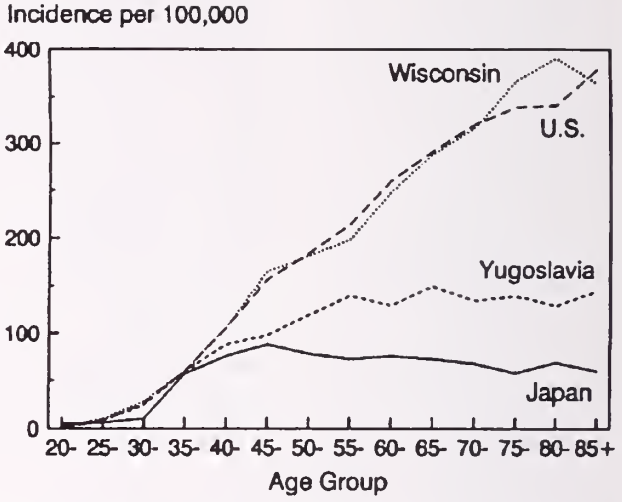

Fig.–Breast cancer incidence by age for women in Wisconsin, the United States, Yugoslavia and Japan.

Results

As shown in the figure, breast cancer incidence increases steadily with age in both Wisconsin and the United States. The age-specific rates for Wisconsin women are remarkably similar to national rates in all age groups.

Wisconsin, Japanese and Yugoslavian women under the age of 40 have a similar low incidence of breast cancer. Around age 40, breast cancer incidence increases in all populations under study, although the rate of increase for Wisconsin women is greater. For women age 50 and older, there is great disparity in

Lantz is a senior research specialist in the Center for Health Policy and Program Evaluation and a PhD candidate at the University of Wisconsin-Madison. Dr Remington is a medical epidemiologist in the Chronic Disease Surveillance Unit, Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Part of this work was made possible by a grant from the National Cancer Institute (#R01-CA-46883). Reprint requests to: Patrick L. Remington, MD, Wisconsin Division of Health, PO Box 309, 1 W Wilson St, Madison, WI, 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin.

breast cancer incidence in the three populations. In Wisconsin (and the United States), there is a significant increase in the breast cancer incidence rate with age. For both Wisconsin and US women, incidence increases by almost 60% between the ages 50 and 65, and doubles between the ages of 50 and 80. In Yugoslavia, there appears to be a small increase in incidence with age, with the incidence rate rising by 20% between the ages of 50 and 85. In contrast, the Japanese women at the greatest risk for breast cancer are in the 40-49 age range, with the incidence rate for post-menopausal women actually decreasing with age.

In terms of relative risk, Wisconsin women are more than twice as likely to develop breast cancer as Japanese women between the ages of 50 and 59, are more than three times as likely between the ages of 60 and 69, and are more than four times as likely after age 70.

Comment

Breast cancer incidence is strikingly different among women ages 40 and older in Wisconsin (and the United States), Yugoslavia, and Japan. The substantial cross-national variation in breast cancer incidence is likely due to cultural or behavioral factors rather than genetic differences. Migrant studies have shown that the daughters and granddaughters of Japanese women who move to the United States have incidence rates approaching those of US whites.[5] In addition, breast cancer mortality rates among third-generation Japanese women are virtually the same as those for the general US population.

What behavioral factors could account for the higher rates of breast cancer incidence among Wisconsin and US women as a whole? The table lists some of the risk factors for breast cancer that are suspected as being related to a higher incidence of disease among US women. Of these risk factors, dietary fat has received

Risk factors suspected as being related to the higher incidence of breast cancer in the United States.

Confirmed Risk Factors

- nulliparity
- first full term pregnancy age 30 or older

Suspected Risk Factors

- diet high in fat
- obesity
- moderate to heavy alcohol use
- use of exogenous hormones
- no or short durations of lactation

Continued on next page

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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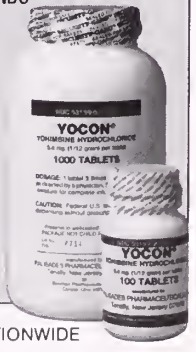

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the most attention. Ecologic studies have shown strong correlations between per capita fat consumption and breast cancer incidence.[1]

The contribution of dietary fat and other factors to the higher rate of incidence in the United States, however, is difficult to assess for two reasons. First, the relationship of dietary fat, alcohol, and other risk factors to endogenous hormones and the role of these factors in breast cancer etiology has not been clearly established. Second, there is a paucity of cross-national individual data on diet, alcohol consumption, and other behaviors–data which are needed before cross-cultural hypotheses regarding incidence differences can be investigated.

If Wisconsin women had the same age-specific risk of breast cancer as women in Japan, the number of cases of this disease would be reduced by more than two thirds, about 2,000 fewer cases annually. Unfortunately, at this time the evidence for the role of such lifestyle behaviors as low dietary fat or low alcohol consumption in Japanese women's lower risk of breast cancer is suggestive rather than confirmatory. Nonetheless, patients interested in reducing their risk of breast cancer can be given the prudent advice that reducing saturated fat in the diet and moderating alcohol consumption may have a protective effect. Given the high level of risk among Wisconsin women, however, and given the current limitations in our understanding of the causes of breast cancer, early detection through routine clinical examination and mammography screening will continue to provide the best opportunity for reducing the burden of this common disease.

Acknowledgements

The authors appreciate the comments made by Peter Layde, MD, of the Marshfield Medical Research Foundation, and Dennis Anderson, Susan Latton, and Judith Zvara of the Wisconsin Division of Health.

References

1. Armstrong B, Doll R. Environmental factors and cancer incidence and mortality in different countries, with special reference to dietary practices. *Int J Cancer.* 1975;15:617-631.
2. Kelsey JL, Gammon MD. The epidemiology of breast cancer. *CA 1991*; 41(3):146-165.
3. National Cancer Institute: Surveillance, Epidemiology and End Results Program. *Cancer incidence and mortality in the US.* 1973-81. US Department of Health and Human Services, National Institutes of Health, NIH Publication #85-1837, revised November, 1984.
4. Muir C, Waterhouse J, Mack T, et al, (eds). Cancer on Five Continents, Vol 5. IARC Publication No. 88. International Agency for Research on Cancer and International Association of Cancer Registries, Lyon, France, 1987.
5. Buell P. Changing incidence of breast cancer in Japanese-American women. *J Natl Cancer Inst.* 1973;51:1479-1483❑

Reporting written policies on abortion

The Abortion Prevention and Family Responsibility Act of 1985 {Wisconsin Statute 146.78 (5)} requires that each hospital, clinic or other facility which performs abortions have a written policy encouraging minors who are seeking abortions to notify their parents. The statutory language specifies some of the things that must be included in the written policy. This policy must also, according to statutory requirements, be submitted annually to the Wisconsin Department of Health and Social Services. Please send copies of these policies by Oct 1, 1991 to: Parental Notification, Assistant Administrator, Division of Health, PO Box 309, Madison, WI 53701-0309.

This statute also contains provisions related to informed consent for abortions {ss 146.78 (1-31)}. Specifically, the attending physician or the person who is assisting the attending physician is required to provide certain information to all women seeking abortions. The information is to be provided prior to the abortion being performed. If a woman requests written information on pregnancy and family planning related services, the attending physician or the person assisting the attending physician is required to provide her with that information. Materials are available from county departments of social or human services. The law also requires that the woman sign a statement acknowledging that she consents freely and without coercion to the abortion.

Copies of the statute and more information about the provisions of the Abortion Prevention and Family Responsibility Act of 1985, are available from the Division of Health at the address listed above or call the division's public information officer at 608-266-1511.❑

New fraud and abuse safe harbor rules go into effect

After 4 years of drafting and receiving more than 750 comments, including those from the SMS, the Office of the Inspector General (OIG) issued the Medicaid-Medicare anti-fraud and abuse rules on July 25, 1991. The rules became effective July 29, 1991. By narrowly interpreting safe arrangements under the broad federal statute prohibiting kickbacks, referral fees, and other illegal remuneration between health care providers, the OIG intends the rules to help curb the reportedly widespread abuse of the Medicaid and Medicare programs by health care providers billing the federal government millions of dollars for overused services and procedures.

The new rules address health care provider investment in joint ventures and limited partnerships protected from prosecution, a subject previous rule drafts failed to define. The new rules describe safe investment arrangements between health care providers for facilities to which Medicaid and Medicare patients may be referred, including the so-called bright line test described by the rules, which allows for a no greater than 40% investment by health care providers who are in the position to refer patients, and that no more than 40% of the revenue is generated by referrals by such investors.

Joint ventures must meet other criteria to avoid prosecution by the OIG, including: a physician investing in a business may not be offered preferential terms based on the number of patients referred to the business; a health care business may not require physicians to refer patients or "otherwise generate business for the entity as a condition for remaining as an investor"; and payments to an investor "must be directly proportional" to the amount of his or her investment and may not be tied to the amount of business generated by that investor.

According to some experts, there are few joint ventures currently meeting the rules' criteria. To avoid prosecution, existing joint ventures may need to disband, avoid Medicare and Medicaid program involvement, or recruit disinterested outside investors to avoid the 40/40 standard. It is important to understand, however, that failing to meet the rules'

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standards do not make an otherwise proper arrangement illegal, only vulnerable to OIG investigation and prosecution.

According to the commentary accompanying the published rules, two additional safe harbor regulations concerning managed care arrangements are forthcoming as well as regulations in the areas of joint ventures involving only active investors, referrals to an entity where the referring physician performs the service, physician recruitment, payments subsidizing malpractice premiums, cross referral arrangements; cooperative hospital services arrangements, and payments between corporations with common ownership.

The SMS submitted comments asking for leniency in defining proper joint ventures between physicians and other health care providers, and demonstrated that many Wisconsin communities lack other available financing necessary for diagnostic equipment. There appears to be no flexibility in the rules, however, for predominately health care provider-financed joint ventures necessitated by these economic and demographic factors.

Although there is no grace period, federal officials have stated they are unlikely to take action against businesses making good faith effort to comply with the law. Physicians involved in arrangements violating the anti-fraud and abuse law face possible criminal penalties of up to 5 years in prison or fines up to $25,000 each violation.

The SMS Office of Legal Services encourages physicians concerned about participation in joint ventures to contact the venture's business office or legal counsel to determine if the arrangement is legal under the new rules.❑

The legend of a country doctor

Russell King, editor

I did not wish to live what was not life, living is so dear. I wanted to live deep and suck all the marrow of life...

More than a century later, Henry David Thoreau's meaning falls like a heavy dew over a 2-acre patch of pines in Ladysmith, Wisconsin. If you are quiet, you can hear the wind in the trees whisper a warm echo, and the man who stands in the middle of this evergreen garden, the sculptor of this living monument, seems to hear it clearly.

After 80 years of living deeply, his shoulders are still broad and his hands are still strong. His eyes turn toward the top of a row of pines, and he seems to listen while his mind forms responses to questions. His answers show that, after 80 years of living deeply, his thoughts are also broad and his intellect is also strong.

William B.A.J. Bauer, MD, has sucked all the marrow of life, and his hunger for it remains as robust as his enjoyment of it.

The son of a physician, brother of three physicians, brother-in-law to one physician, father of two physicians, and father-in-law to two physicians, Bauer earned his medical degree from the Long Island College of Medicine in 1939. He married Augusta "Gussie" Ahrens that same year, and the two of them moved to Ladysmith in 1942.

Bauer fell in love with Wisconsin's woods and trout waters, but was frustrated that he could not visit them as often as he liked. So, he built a woodland trout habitat around his home. As so many country doctors do, he often cared for families who were unable to pay for his services but too proud to accept charity care. Barters were arranged. Sometimes he took farm produce, sometimes a load of boulders for terracing the hill, and sometimes trees. Bauer has planted hundreds of trees and, although he continues to plant and landscape, most of them are now mature and provide a towering green buffer between the Bauer home and the rest of the world. He shrugs off the feat with a humble smile. "You recall what Mohammed did when he could not go to the mountain..."

The centerpiece of this "mountain" is a trout pond about 30 yards long and 15 yards across, 18 feet at its deepest (dug by hand). The pond is fed by water flowing from a series of smaller ponds (also dug by hand) that descend the terraced (by hand) hillside. At the top is a hatchery where in earlier times Bauer conducted experiments on trout life cycles and growth. The water comes from a well that Bauer dug by hand

Continued on page 545

Wanted: unforgettable characters

As part of the introspection and reflection that comes naturally to an organization turning 150 years old, the *Wisconsin Medical Journal* would like to feature the colorful, the admirable, and the unforgettable physicians of Wisconsin. If you know of a physician who you think may merit being featured in the *WMJ*, drop us a line telling us who and why. Or, if you prefer, write the story yourself and submit it for consideration. We can't promise to feature everyone suggested, but we'll strive for a good sampling. Write to: "Historical Profiles" *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.□

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Thomas L. Adams, CAE (l) visits with William B.A.J. Bauer, MD, (r) at the Bauer home in Ladysmith.

Continued from page 543

in his basement and gives life to trout ranging to 36 inches. A handmade wooden bridge crosses the largest pond and connects to a handmade lattice of wooden walkways that encircle the ponds. At their most productive, the hatchery and ponds held 50,000 trout.

Bauer is one of Wisconsin's leading authorities on trout and trout fishing, and his book *Brethren of the Brule* looks back on the rich experiences, wealth of knowledge, and host of lasting friendships he gathered during 40 years of fishing Wisconsin's best trout stream, the Brule River. It is a labor of love, but is also a labor of considerable humor and intelligence. Bauer approaches the river, the trout, and the time he spends in the former pursuing the latter a number of very different ways: as a lover, for whom the Brule is an innocent mistress; as a philosopher who finds deeper meanings in the currents, and who writes poetry about them; as an historian who understands that his "claim" to the river is temporary and that his place in its history carries certain responsibilities; as a scientist who studied things such as what affects trout growth rates, and what makes the fish's flesh firm or soft and red or white; and as a fisherman, offering tall fish tales and advice on everything from where to find trout to how to cook them.

"The Brule River flows on," he wrote, "as it elicits a special beauty to those who would but look, a special music to those who would listen, and a special feeling to many who have looked and listened.... As the mists of the past close in, I am suddenly aware that I, too, have been captivated by this reverence for a river."

No less an outdoorsman than Mel Ellis wrote the foreword, and he offered this: "First there were Indians. Then came the explorers, missionaries, voyagers, adventurers, and then came Doc.... Some day Doc won't come. I'm sure the river will know, and I'm sure the river will mourn, because their's was a rare brotherhood, born of and nurtured by an association which can only be described as eternally spiritual."

Bauer is seeking a publisher for his second book, a memoir of his 50 years in medicine, while he writes children's stories, poetry, and a philosophical advice column for two Rusk County newspapers. He has published in numerous state and national outdoor magazines, as well as scientific articles in medical journals. His involvement in the local Kiwanis Club and the Wisconsin Conservation Congress were rewarding for him.

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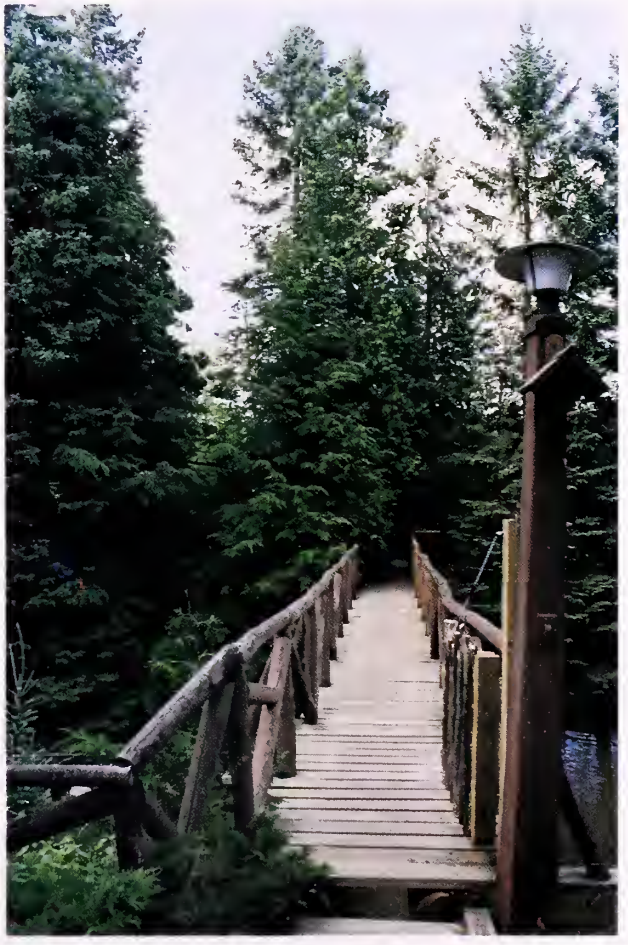

The handmade bridge that spans the Bauer trout pond.

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As a physician, he is best known by his patients who knew him as a confidant of great principle, strength, and compassion. But the record of Bauer's career reveals him as a fierce advocate for medicine and the public welfare, having vigorously taken up the causes of fluoridated water, liability reform, medical ethics, the Medicare hassle factor, and access to health care in rural Wisconsin.

Access to rural health care continues to weigh heavily on Bauer's mind, as does his apprehension that today's young physicians will be more concerned with the business and technology than the caring human contact of medicine. "I believe it is the lack of personal contact with our patients that has contributed to the public's lack of faith in our profession," Bauer said. "We must avail ourselves of the advantages of medical technology without creating an image of being mechanistic robots."

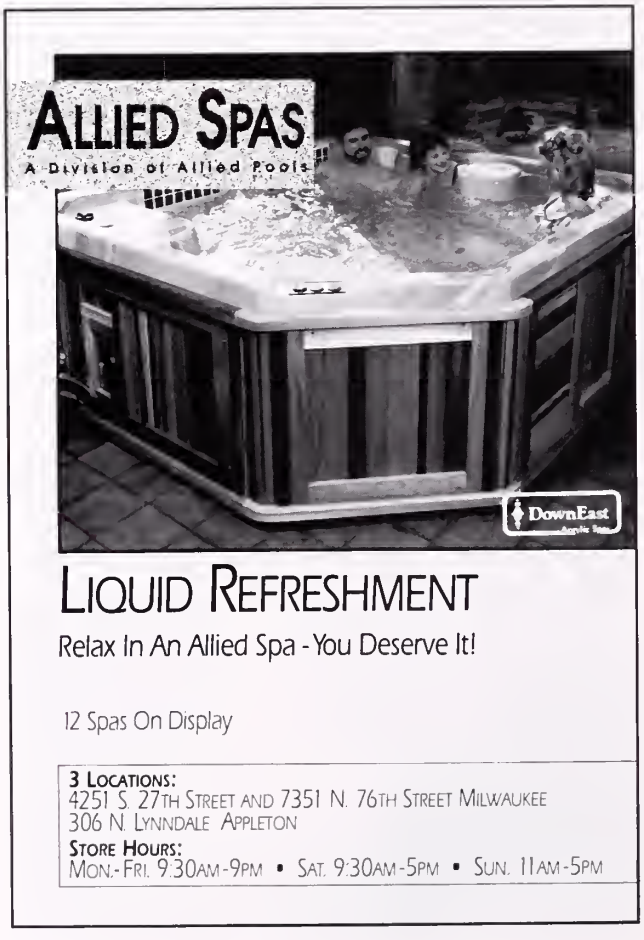
It is, however, the growing public perception that physicians care more for money than they do for their patients that Bauer considers the greatest threat to the future of medicine. He makes no accusations, he simply offers a bit of advice: "Until one goes beyond self-gratification and reaches toward others, there can be no true happiness. Maturity begins when one feels the need to share the responsibilities of others."

Bauer sees the modern trend toward specialization and group practice as positive because, "the accumulated knowledge has become too massive for any individual to absorb, and because the physician has more time to achieve a proper balance between medical life and family life." For most of Bauer's career, he was one of only 5 practicing physicians in Rusk County, which forced them to carry heavy patient loads and stay abreast of a wide range of medical advances. Today, the Marshfield Clinic in Ladysmith alone has 11 physicians on staff, and they can, when necessary, avail themselves of the best of modern medical technology and a spectrum of specialists. Bauer seems grateful that the community for which he cared for so long will continue to receive, as it did in his day, the best that medicine has to offer.

The passing of the torch from one generation of doctors to the next has been, and still is, an important transition in Bauer's life. He speaks with reverence of the physicians who preceded him, among which his father is numbered. Although the science of the medicine he practiced was far more sophisticated than that of his predecessors, he is aware of the debt of gratitude he owes them. "The knowledge of one generation builds on the foundation laid by another," he said. "Our accomplishments were built on theirs." Then the conversation shifts, and Bauer speaks with pride of the generation of physicians who are following in his large footsteps, including two of his children. "The science of medicine changes all the time," he said, "but two things never change: A doctor's best tools are still listening and caring; and while doctors treat, only God can heal."

Bauer pauses and looks again to the tops of the pines. "It's surprising what you learn just being a country doctor." The humility rings true. "I've been blessed and I've enjoyed my medical practice, but more than anything this 50 years of interacting with people has revealed to me how much we need each other."

Thoreau once disguised an axiom as an explanation for living at Walden Pond: "I went to the woods because I wished to live deliberately, to front the essential facts of life and see if I could not learn what it had to teach, and not, when I came to die, discover that I had not lived." And each morning, at a Wisconsin Walden, a country doctor in Ladysmith rises and puts the principle to work.❑



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Highlights from the SMS Board meeting

At the July 20, 1991, SMS Board of Directors meeting, the Board heard a summary of the effect of Medicare physician payment reform and the RBRVS conversion factor. Three key areas where changes are proposed were discussed: the conversion factor, relative value units, and geographic practice cost indices. The Board discussed and approved requesting that HCFA reduce Wisconsin's Medicare payment localities from 11 to 1, and discussed the larger issue of the inequities that exist in HCFA's national policy of geographic payment differentials. SMS comments to HCFA administrator Gail Wilensky, PhD, regarding HCFA's proposed rule making on RBRVS were adopted. The Board also:

- adopted the SMS Health Care Financing and Delivery Committee's recommendations to accept the report and recommendations of the Coalition Quality Data Task Force, and for the SMS to continue to be an active participant in discussions and activities of the coalition. It was also accepted, upon the committee's recommendation, that the SMS continue to emphasize its concerns about the limitations of UB-82 systems for reviewing the quality of health care;
- heard presentations from Wisconsin Manufacturers and Commerce and the Wisconsin Hospital Association regarding their views on the collection and dissemination of physician-specific health care data, and discussed the Office of Health Care Information's development of rules governing the collection of data from physicians and other health care providers and SMS's response;
- endorsed the "Happy Birthday Two Year Old" program, which is designed to increase vaccination coverage for young children who might otherwise escape age-appropriate vaccinations until they enter school;
- approved the SMS Task Force on Relationships Between Medical Schools and the Medical Community's recommendations, which include naming the president of the Medical College of Wisconsin and the dean of the UW Medical School as "ex-officio advisors to the SMS Board of Directors without vote," and the formation of permanent discussion groups from each medical school;
- adopted the SMS Maternal and Child Health Committee's recommendations on school-based clinics to provide comprehensive primary health care services where the health care needs of the adolescent population are not being met;
- adopted the SMS Physicians Alliance Commission's position on a number of bills, and supported state funding for the Tobacco Research and Intervention Program; and
- approved the Interprofessional Code Committee's chapter on advance medical directives, written to help physicians and attorney's understand the problems that each may have in this area, and thus, better serve the patient/client.

SMS opposes proposed Medicare reductions for new physicians

The SMS is asking Congress to reject new rules, proposed by the Health Care Financing Administration, that would lower reimbursement rates new physicians.

Currently, Medicare limits reimbursement for physicians in their first 4 years of practice. First-year physicians are limited to the lower of the 50th percentile prevailing charge or 80% of the adjusted prevailing charge. Second, third, and fourth-year physicians are capped at 85%, 90% and 95% of the adjusted prevailing. New physicians practicing under a single Medicare clinic provider number are not subject to the limitations, and these reductions do not apply to primary care services or services furnished in Health Professional Shortage Areas.

Under the proposed RBRVS regulations, effective Jan 1, 1992, all physicians in their first 4 years of practice, including those practicing under a single clinic provider number, will be subject to reimbursement reductions. The payment reductions will be taken from the fee schedule value, rather than from adjusted prevailing charges. HCFA has also defined that the "first year" will be the first full calendar year during which the physician is in practice from January to June (thus may be longer than 12 months); the second, third, and fourth years will be based on a calendar year.

The SMS has urged members of Congress to eliminate these payment reductions, since this policy is inconsistent with RBRVS reforms, and has recommended to Gail R. Wilensky, PhD, HCFA administrator, that this policy not be expanded to include medical groups. ❑

Continued on next page

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The Board also heard reports from the Physicians Insurance Company and the Patients Compensation Fund (PCF) Task Force, which held its first meeting to begin reviewing the function and operation of the PCF.

Patricia Stuff, MD, discussed the Wisconsin resolutions presented before the AMA House of Delegates at the annual meeting. Dr Stuff announced that the SMS received several awards for increasing AMA membership throughout the state. Physicians who were recognized include: William L. Kopp, MD, for recruiting four new members through the AMA's Hospital Medical Staff Section Outreach Program; Kevin T. Flaherty, MD, for recruiting 18 new members to the AMA Young Physicians Section; and Kermit Newcomer, MD, for recruiting 22 new AMA members through the AMA House of Delegates Outreach Program. Dr Stuff thanked the many other Wisconsin physicians who helped in this effort.❑

Persian gulf physicians honored at SMS Board meeting

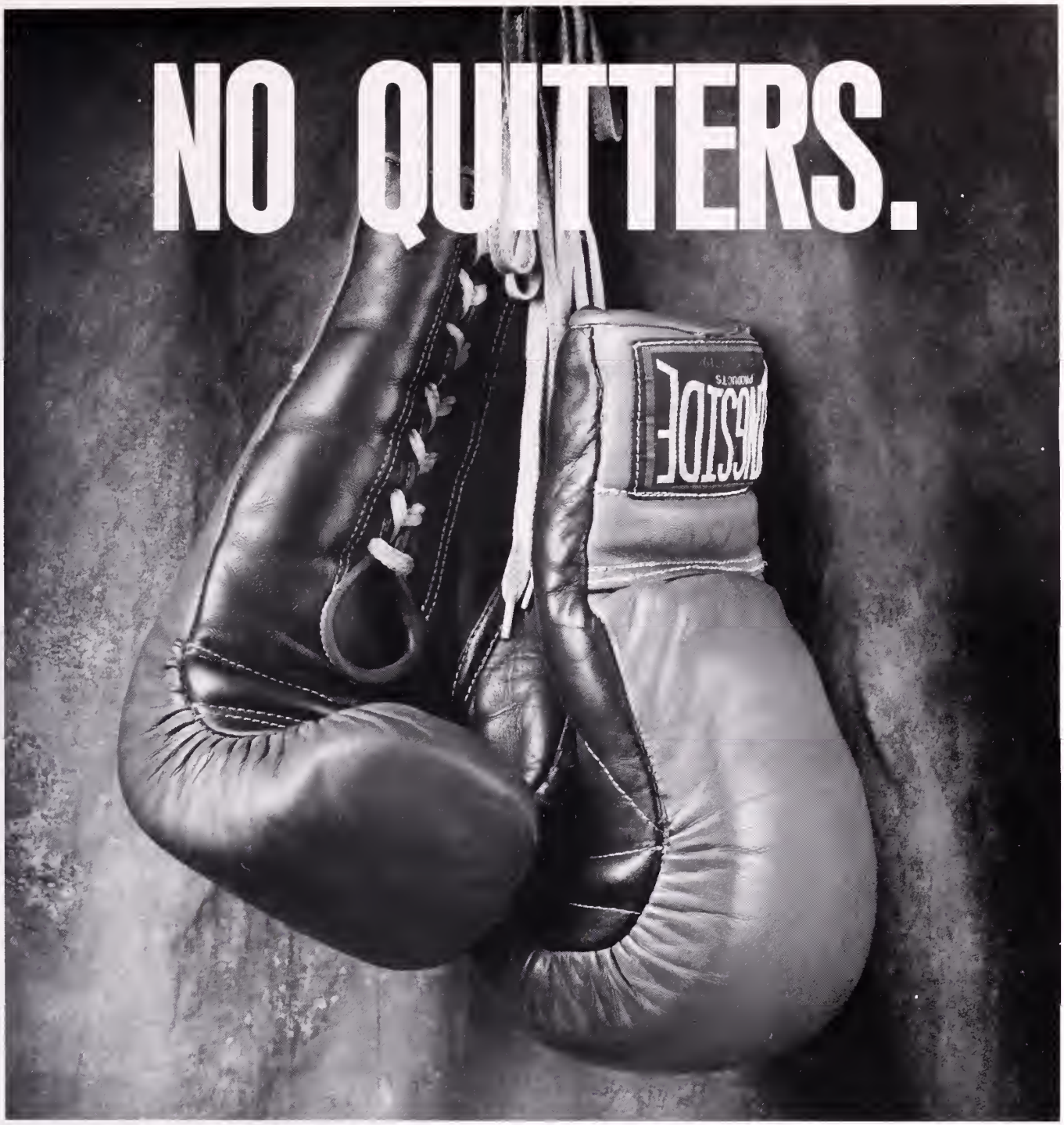
A SPECIAL CEREMONY was held at SMS headquarters, in conjunction with the Board of Directors meeting, honoring those physicians who served in the Persian Gulf War with the Presidential Citation award. SMS President Cyril M. "Kim" Hetsko, MD, of Madison presented the awards.

"The Presidential Citation award you are receiving today is about the selflessness, the compassion and the spirit of sacrifice that signify what is most noble in us–as humans, as citizens and as physicians," said Dr Hetsko. "This award expresses our gratitude to you who put those characteristics into action and who have reminded us who we are and what we are about."

A list of physicians who the SMS has confirmed as serving in the Persian Gulf War is below. The SMS is aware that some physicians may not have been listed on the information we obtained from the military. If you or someone you know were also activated into service as a result of Operation Desert Storm, contact the SMS Division of Communications.

SMS President Cyril M. "Kim" Hetsko, MD, (l) presents Haywood S. Gilliam, MD, (r) with a Presidential Citation.

Manuel M. Aquino, MD
David P. Athas, MD
Steven W. Babcock, MD
Michael W. Bachhuber, MD
Jergen L. Barber, MD
Arthur Barbier, MD
David O. Barger, DO
Ronald E. Beresky, MD
Larry R. Boehme, MD
James H. Brandenburg, MD
Jonathan Jay Brodie, MD
Dwight H. Brown, MD
Albert R. Bryan, MD
Richard W. Clasen, MD
Michael C. Collopy, MD
Mark A. Coppes, MD
James E. Engeler, Jr., MD
Michael C. Fiore, MD
Haywood S. Gilliam, MD
John H. Gray, MD
Helen J. Gurkow, MD
Lewis B. Harned, MD
Jonathan E. Hasson, MD
Charles J. Havel, Jr., MD
Joseph L. Hodgson, MD
John G. Jaeger, MD
Stephen M. Lindsey, MD
John E. Martin, MD
Thomas M. McCarthy, MD
Eugene McClellan, MD
Michael R. McFadden, MD
David J. Morrison, MD
David L. Paton, DO
Guenther P. Pohlmann, MD
Paul M. Schoenfeld, MD
Timothy J. Shaw, MD
Martin J. Van Every, MD
John J. Vondrell, MD
Brian D. Wake, MD
Ronald V. Washak, DO
John W. Weiss, MD
Janet A. Wilson, MD
Donald J. Zoltan, MD❑



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SMS meeting with HCFA is constructive

Representatives of the SMS met with representatives of the Health Care Financing Administration (HCFA) in Milwaukee July 31, 1991. The discussions centered on documentation requirements for home oxygen and durable medical supplies; the appeals process; payment reform; and changes in visit codes.

SMS Presdient Elect William J. Listwan, MD, was one of the Society representatives who considered the meeting constructive: "Although I will stop short of singing the praises of Medicare and HCFA, I must honestly say that I thought the meeting was worthwhile. It was interesting and served a useful purpose. Any forum that brings a Medicare administrator face to face with sincere, hard working physicians like family practitioner Charlie Pechous, an SMS Board member from Kenosha, has to have value."

Practicing physicians and clinic administrators also gained by being able to talk in a casual forum with some of the people at HCFA who were responsible for implementation of HCFA policies and who can make some changes.

HCFA was made aware of the SMS' concerns about the language used on the Explanation of Medicare Benefits (EOMB) forms and indicated that new language was being developed that would better convey the message intended and would have "better tone." The SMS also asked that HCFA give advance notice of changes in the wording used on EOMB forms so that physicians would have time to prepare for patient questions about some of the phrases used. The recent example of "You could have avoided paying $___ if the claim had been assigned" was used as an example.

HCFA also used the opportunity to solicit comments from those present about possible changes in audit procedures, requirements for justification of durable medical supplies, and some of the problems that will be encountered during the change-over in January 1992, involving the use of new visit codes for office and hospital visits.

"I hope it is one that will be repeated in various places and at various times over the years," Listwan said of the meeting. "Clearly, HCFA seems interested in the view points of physicians, clinic managers, and our medical societies."❑

Physician briefs

The * indicates an SMS member.

Kenneth A. Miller, MD,* of Rhinelander, recently joined the practice of **Glen Smiley, MD,** of Delavan, at the Lakeland Medical Center. A family practice physician, Dr Miller moved to Wisconsin from Hawarden, Iowa.

Robert J. Bugarin, MD,* of Tomahawk, recently joined the Tomahawk Medical Center, a division of the Rhinelander Medical Center. A family practitioner, Dr Bugarin received his medical degree from the University of Wisconsin-Madison. He completed his internship in 1986 and studied his residency in surgery at the University of Wisconsin Hospital and Clinics.

Loren R. Keldahl, MD, of Minocqua, recently joined the staff at Marshfield Clinic-Lakeland Center. An urologist, Dr Keldahl earned his medical degree, and completed his internship and residency at the University of Minnesota in Minneapolis.

Vincent Miller, MD, of Chippewa Falls, recently joined the Marshfield Clinic-Chippewa Center. A neurocerebrovascular specialist, Dr Miller completed his medical degree at the University of Illinois College of Medicine at Peoria. He completed a neurology residency at Northwestern Memorial Hospital in Chicago.

Diana J. Lampsa, MD,* and **Brian J. Eggener, MD,*** of Manitowoc, recently joined to form Great Lakes Psychiatric Associates. Both physicians completed their medical degrees in 1985 and psychiatric residency in 1989 at the University of Wisconsin-Madison.

Patrick James Murphy, MD,* P. Perry Phillips, MD,* and **Lorne P. Schlect, MD,** of Sheboygan, recently joined the staff at the Sheboygan Clinic. Dr Murphy, a family

Continued on page 554

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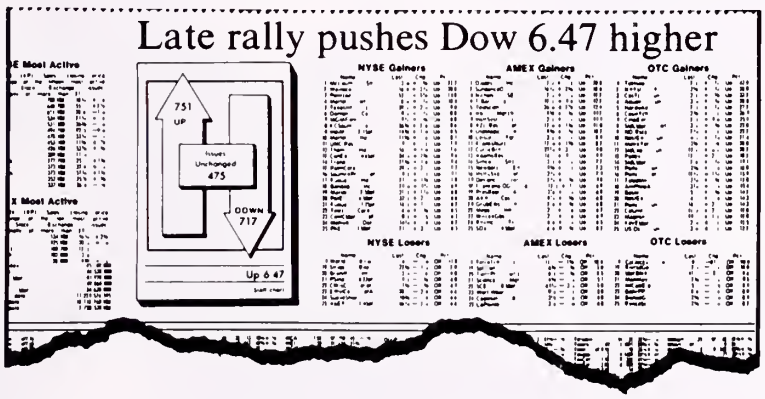

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Sometimes, it can be better to give than to receive.

American Heart Association

This space provided as a public service.

Continued from page 552
practitioner, received his medical degree from the Medical College of Wisconsin and completed his family practice residency at the Waukesha Family Practice Residency Program. Dr Phillips, an otolaryngologist, earned his medical degree and completed his residency at the University of Oklahoma College of Medicine. Dr Schlect, an ophthalmologist, received his medical degree at the Mayo Medical School and completed his internship at Boston University.

Joseph Bonnano, MD, of Chilton, recently joined the staff at Calumet Medical Center. He received his medical degree from the Robert Wood Johnson Medical School in New Jersey. He completed an internal medicine residency at the North Shore University Hospital in New York City.

Sandra Kamnetz, MD,* of Madison, recently joined Physicians Plus Sun Prairie Family Practice Center. A family practitioner, Dr Kamnetz is a graduate of the UW School of Medicine, and was appointed clinical associate professor in the department of medicine at the University of Wisconsin.

David Pittenger, MD,* of Milton, has joined the Janesville Medical Center staff. An orthopedic surgeon, Dr Pittenger is a graduate of the Medical College of Wisconsin and completed his residency at Blodgett Memorial Medical Center in Grand Rapids.

Continued on page 556

Memorials made through the CES Foundation

Memorial gifts made from January through June 1991

Thomas and Diane Adams
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Donald G. Dieter, MD
Dr and Mrs Richard Edwards
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John LaBissoniere
Dr and Mrs George Nadeau
E. J. Nordby, MD
Dr and Mrs Robert Schmidt
Donald A. Smith, MD
Margorie Stafford
Patricia Stuff, MD, and family
Norma Swenson
Richard H. Ulmer, MD
Dane County Medical Society
Douglas County Medical Society
State Medical Society of Wisconsin

In Memoriam
In loving memory of those individuals who will grace our paths forever.

Paul J. Ambro, MD
Richard Boland, MD
Dawn Brehmer
Arnold Biebel
Barbara A. Brew, MD
Marshall O. Boudry, MD
Glenn A. Dall, MD
Einar R. Daniels, MD
Dean M. Dreblow, MD
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Bea Mayhew
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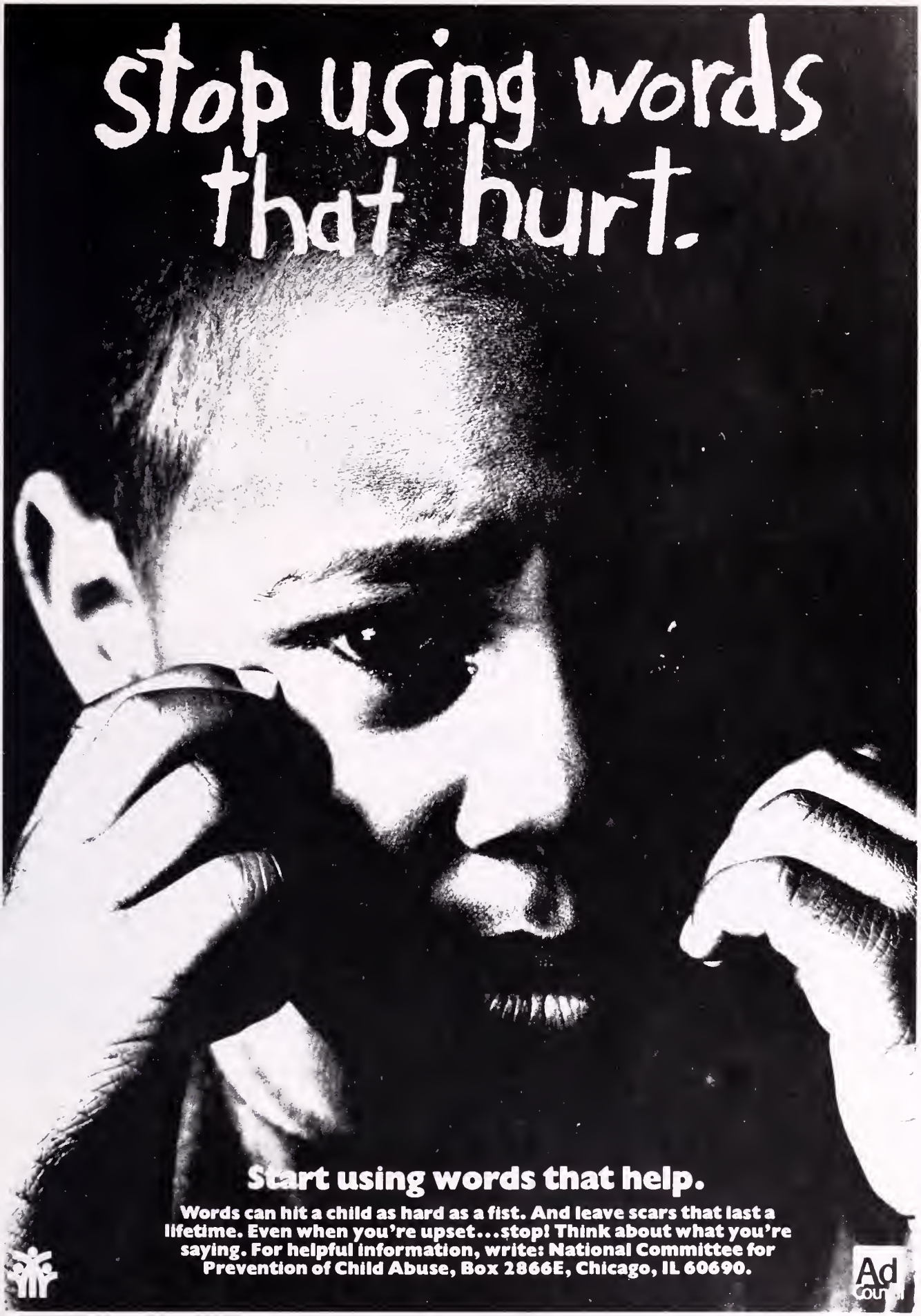
Hugo Traupmann
Leona Valley
David J. Werner, MD
Dorothy Wittman
James Yonke
F. Frank Zboralske, MD❑

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❑



Wisconsin Committee for Prevention of Child Abuse, 1045 E. Dayton St., Rm. 202D, Madison, WI 53703. (608) 256-3374

Continued from page 554

Al Neuhoff, MD, of Eagle River, recently joined the North Twin Medical Associates. A family practitioner, Dr Neuhoff received his medical degree from the University of Iowa.

Kristen Bruxvoort, MD, of Bloomer, recently joined the Blue Diamond Family Practice Center in Bloomer. A family practitioner, Dr Bruxvoort received her medical degree from the University of Wisconsin Medical School.

Marc H. Stolar, MD, of Chippewa Falls, recently joined the Marshfield Clinic-Chippewa Center. A psychiatrist, Dr Stolar received his medical degree from the University of Illinois in Chicago and completed a psychiatry residency at the University of California Medical Center in Irvine.❑

SMS president speaks at Wisconsin conference on health care

On July 22, 1991, SMS President Cyril M. "Kim " Hetsko, MD, of Madison, spoke to attendees of the Wisconsin Conference on Health Care at the Marc Plaza in Milwaukee.

Dr Hetsko outlined organized medicine's proposals for reform of the current health care system. US Rep Jim Moody (D-Wisc) called the conference on health care system reform and more than 400 people from across the state gathered to address various health care issues.

Other speakers included: Gail Wilensky, PhD, HCFA administrator; US Rep Pete Stark (D-Calif); and Uwe Reinhardt, PhD, professor of political economy at the Woodrow Wilson School of Public and International Affairs.❑

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SMS secretary-general manager hears physicians' concerns

THOMAS L. ADAMS, CAE, secretary-general manager of the SMS, recently meet with physicians at the Marshfield Clinic in Ladysmith as part of his statewide physician outreach efforts. The frank and lively discussion included topics such as: the RBRVS, geographical payment differences for Medicare; Medicaid reimbursement; medical liability reform; proposals for a national health care plan; the Patients Compensation Fund; the importance of grassroots political activity; and the SMS efforts to contain costs.

The Marshfield Clinic in Ladysmith.

The 11 physicians at the Ladysmith clinic are particularly involved in state and local politics and active in the struggle to improve access to health care in rural Wisconsin. Howard Chatterton, MD, described recruiting physicians to rural health care as frustrating. He said the reasons most commonly heard from recruits who decide against a rural practice are: professional opportunities for the physician's spouse are inadequate; the physician does not wish to live so far from his or her family; and that there are too few medical facilities in the area. Generally, according to Chatterton, those who practice rural medicine simply have a preference for rural life.

Thomas L. Adams, CAE, (second from l) meets with the physicians of the Marshfield Clinic in Ladysmith.

"One of the chief advantages for me," Chatterton said, "is that I am part owner of a group and not just an employee. Also, you can practice as broad a spectrum of medicine as you are qualified for; for instance, you don't have to fight for OB privileges. Because there is not much competition, your patients come to see you first and you have the opportunity to manage cases that you might never see in urban health care. You can really challenge yourself to see what you're capable of."

Adams is available for meetings with physicians throughout the state and eager to hear what is on your mind. To arrange a meeting, contact the SMS Division of Public Affairs field staff at 1-800-362-9080 or (608) 257-6781.❑

Dr. Humerus?

Rumor has it that physicians take themselves too seriously, and the *WMJ* Editorial Board wants to prove the rumor wrong. The Board wants to hear your best doctor jokes - no holds barred. Publication is possible. Send them to: Doctor Jokes, c/o *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❑

Wisconsin Medical Journal instructions to authors

Authorship

Manuscripts are considered with the understanding that they have not been published previously and are not under consideration by another publication.

Each scientific and socioeconomic manuscript must be accompanied by a cover letter containing the following sentence: "In consideration of the *Wisconsin Medical Journal*'s taking action in reviewing and editing this submission, the author(s) hereby transfer(s), assign(s), or otherwise convey(s) all copyright ownership to the *WMJ* in the event that this work is published in the *WMJ*." All co-authors must sign the letter.

The cover letter must also designate one author as correspondent and provide a complete address and telephone number. All coauthors should have contributed to the study and manuscript preparation. They should be thoroughly familiar with the substance of the final manuscript and be able to defend its conclusions.

The *Journal* expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. All funding sources supporting the work should be routinely acknowledged on the title pages, as should all institutional or corporate affiliations of the authors.

Editing

All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

Preparation of scientific manuscripts

- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
- Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.
- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
- Organization for scientific papers:

Abstracts–150 words or less, stating the problem considered, methods, results and conclusions. Cite no references.

Methods–Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results–Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion–Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

References–Limit to 20. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

- Acknowledge all illustrations and tables taken from other publications, and submit written permission to reprint from the original publishers.

Style

- Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors* and AMA *Manual of Style*.
- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
- Authors are responsible for supplying the full and correct names of drugs. Use generic names of drugs, unless the specific trade name of a drug is directly relevant to the discussion. If the author so desires, brand names may be inserted in parentheses.
- Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.
- Provide each author's full name and highest academic degree in the

byline. If an author holds two doctoral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

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Authors are encouraged to submit black and white photos, graphs and charts when such illustrations will aid in the readers' understanding of the article. If color illustrations, suitable for use on the *WMJ* cover are available, the author should notify the *WMJ* office when the paper is submitted. Use of art submitted as cover illustrations is not guaranteed.

Review process
Each scientific manuscript is reviewed by the medical editor and the members of the editorial board. The opinions of outside consultants may be sought at the medical editor's discretion. The medical editor has the final decision as to whether a scientific paper will be published.

Socioeconomic manuscripts are reviewed by the SMS senior staff and legal counsel. As publisher, the SMS secretary-general manager has the final decision as to whether a socioeconomic paper is published.

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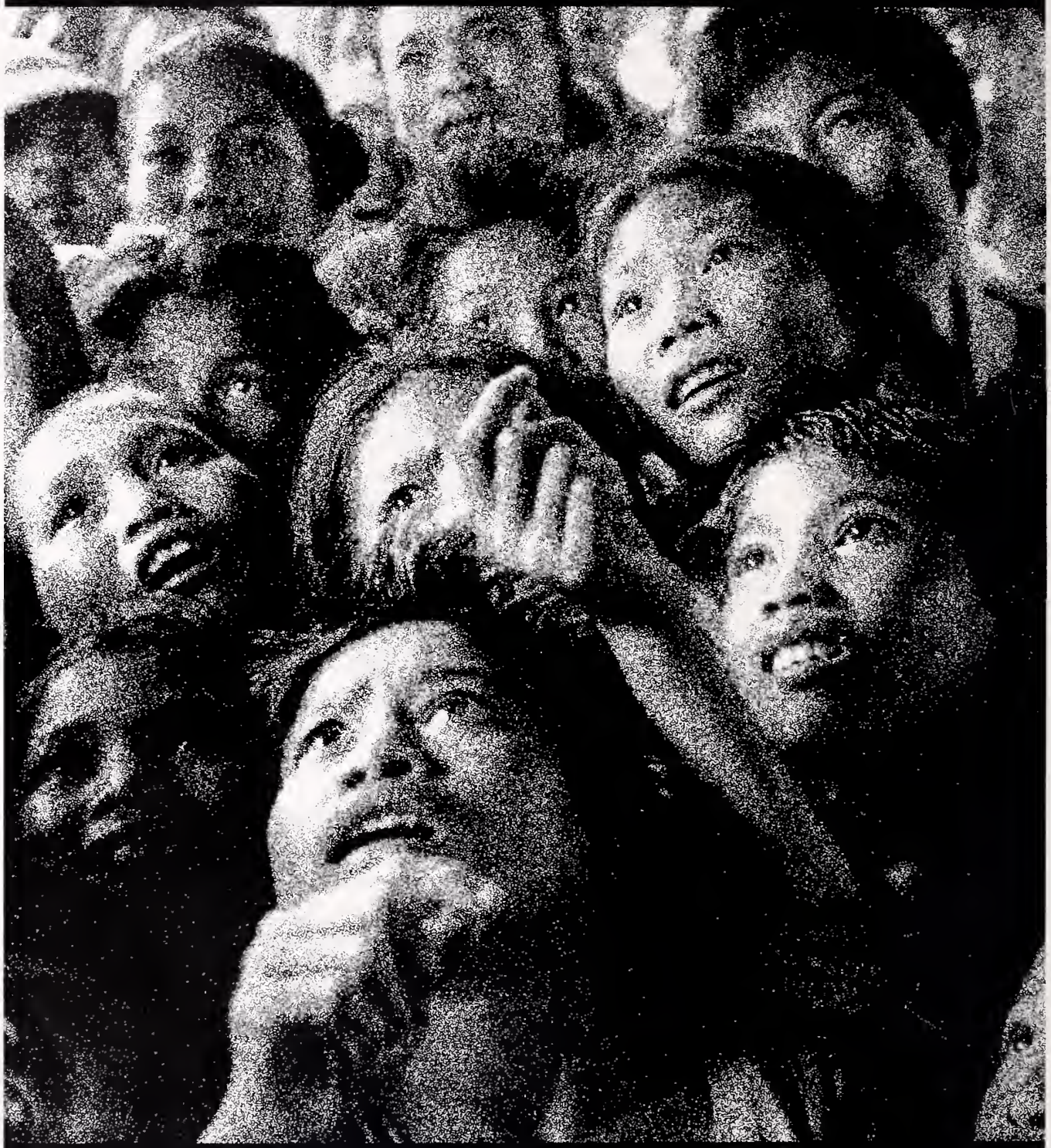

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Madison,Wisconsin-Urgent Care. Dean Medical Center, a 220+ physician multi-specialty group, is seeking two urgent care physicians to join its six member urgent care department. Qualified applicants should be BE/BC in internal medicine, family practice or emergency medicine with experience in pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 am - 11:00 pm. All physicians rotate between both sites and work an average of 40 hours per week. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715 at work 608-252-8022 or home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Osceola on the river St. Croix. Ladd Memorial Hospital and Ramsey Clinic-Osceola are seeking out a family physician to join the well established local group. Osceola, Wisconsin, is situated on the bluffs of one of mid-America's most beautiful waterways, the river St. Croix. Osceola is located 40 minutes northeast of the Minneapolis/St. Paul metropolitan area. This practice opportunity truly offers the perfect balance! For particulars, forward your curriculum vitae or contact: Loriese A. Stoll, Director of Professional Services, Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101; or call collect 612-221-3067. 9-10/91

Suburban Detroit. Beautiful community west of Detroit is experiencing growth boom. Result: tremendous need for BE/BC obstetrician/gynecologist to join an established group. You may expect a busy practice and competitive first year compensation, then production based income. Potential of $280,000. Group benefits include substantial malpractice coverage. Live in the best of both worlds–vibrant and exciting metropolis with access to a myriad of recreational opportunities. To find out more, contact Patience Schock at 1-800-765-3055 or mail your CV to 222 S. Central, Suite 700, St. Louis, MO 63105. 9/91

Madison, Wisconsin. Dean Medical Center, a 220 physician multi-specialty group is seeking three additional family physicians to join its 30 member department. Positions are located at the Arcand Park and West Madison locations, obstetrics is required. Madison is the home of the University of Wisconsin with enrollment of over 40,000 and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits is provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Physician Recruiter, Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715; work 608-252-8022 and home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Private practice opportunities in Minnesota and Wisconsin. Dermatology, emergency medicine, ENT, internal medicine, family practice, obstetrics/gynecology, ophthalmology and pediatrics. Join established groups with strong hospital support in attractive communities. Contact: Jerry Hess, Abbott Northwestern Hospital (16501), 800 East 28th St, Minneapolis, Minn 55407; ph 1-800-248-4921. A lifeSpan member. 9-11/91

Platteville, Wisconsin. Excellent opportunity for a family physician to practice the full range of medicine including obstetrics and join a four person well established family practice group. This is affiliated with Dean Medical Center a 220 multi-specialty group based in Madison, Wisconsin. Platteville is the home of the University of Wisconsin, Platteville, with enrollment of over 5,000 and the Chicago Bears summer training camp. Excellent salary and benefits. Educational loan payment assistance is negotiable. For more information contact Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715; work 608-252-8022 and home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Coastal Wisconsin, enjoy a busy primary care practice in a Lake Michigan resort community. $140,000 guaranteed for two years for qualified candidate. Associate with established FP, on-campus office, 25 minutes from Green Bay, relocation, overheads, benefits, optional OB, low cost of living, live on the water. Call for further details on this and other opportunities at 800-347-7987, ext #1-109, or send your CV to Thomas Schroth at Harris Kovacs Alderman, 4170 Ashford Dunwoody Road, Suite 500, Atlanta, GA 30319. 9/91

Madison, Wisconsin. Dean Medical Center, a growing 200 physician multi-specialty group with over 18 locations is seeking two additional BE/BC internists to join their 25 member department. Madison is the home of the University of Wisconsin with enrollment of over 40,000 and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Physician Recruiter, Dean Medical Center, 1313 Fish Hatchery Road, Madison, WI 53715, work 608-252-8022 and home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Family practice and internal medicine opportunities for BC/BE physicians to join progressive primary care satellite clinics in Barron and Chippewa Falls, Wis. These clinics are part of the Midelfort Clinic, a multi-specialty clinic in Eau Claire, Wisconsin, which is owned and managed by the physicians. An outstanding two year guarantee, bonus, and comprehensive benefit package are being offered. Barron and Chippewa Falls are communities with excellent school systems, wonderful outdoor recreation and quality family life. Close to both Eau Claire and Minneapolis/St Paul, these positions are available due to community growth and demand. Please contact Debbie Bakula, Caswell/Winters, 11400 W. Lake Park Dr, Milwaukee, WI 53224; ph 1-800-235-0488. 9-11/91

Family practitioner and internist to join well established and respected multi-specialty group, with excellent patient base. Our nine physicians practice high quality care, in suburban city located 15 minutes from Milwaukee. Competitive, guaranteed first year salary, with production bonus, plus excellent fringe benefits. Send CV to: Michael Lamping, Clinic Manager, South Milwaukee Clinic, 100 15th Avenue, South Milwaukee, WI 53172; ph 414-762-3680. p9-10/91

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Physicians Exchange

Continued

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. c6-9/91

SE Wisconsin pediatrics. Unique opportunity for 1-2 skilled BC/BE pediatricians. Hospital management and start-up assistance available along with coverage from skilled BC colleagues. Be part of a new practice in a prospering community close to Milwaukee, Madison, and Chicago. Contact Amy Palmer, Professional Relations Director, Waukesha Memorial Hospital; ph 1-800-325-2011. p8;9/91

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes' office at 906-563-9255 or Dr. William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; 906-563-9243. 8-9/91

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Obstetrician/Gynecologist, Ashland, Wis. Medical Associates North, a progressive 17 physician multi-specialty group is currently seeking a BC/BE obstetrician/gynecologist. Current staff includes two Ob/Gyns, 7 FPs, 4 IMs, 1 Ped, and 3 EMs. Extremely competitive salary plus full benefit package. Outstanding quality of life on the shore of Lake Superior. Exceptional school systems, recreational offerings, and clean air! Contact Randy L. Munson at New Physicians for Wisconsin, University of Wisconsin-Office of Rural Health, 5721 Odana Road, Madison, WI 53719; 608-273-5964 COLLECT.
9-12/91;1-2/92

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. c6-9/91

Family practice physician. Board certified/eligible. Exceptional opportunity for a family practice physician to join a progressive and growing group practice in Milwaukee, Wisconsin. Competitive salary. Attractive benefits. Malpractice insurance. CME allowance. If you want to combine professional excellence with personal satisfaction, please send CV to: Mohammad Shafi, MD, Shafi Medical Center, SC, 2000 W. Kilbourn Ave, Suite C312, Milwaukee, WI 53233; ph 414-342-3000. 8-10/91

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Very competitive first year guarantee with benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, Michigan 49801; 1-800-323-8856. 8-9/91

Baraboo, Wisconsin. Seeking internist, family practitioner, general surgeon and emergency department physician. Growing practices require additional physicians in a beautiful, growing rural community. Contact Thomas Warwick, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608-356-1400. 5-10/91

Full-time or part-time physician needed for women's health center. Salary negotiable. Partnership a possibility. If interested please forward a current CV to: Aleksander Jakubowski, MD, 5825 W. Capital, Milwaukee, Wisconsin 53216. p7-9/91

Wisconsin - Fox River Valley. Established nine-physician two-hospital group with 15 years longevity seeks BP/BC emergency physician to fill 10th position. The candidate will be offered a starting package of $165,000 with corporate membership in two years guaranteeing a $200,000 package. Benefit part of package includes 15% retirement, paid malpractice, health, dental, disability, and $4,000 per year CME. ED volume 27,000 per year, average shift 6 days/6 nights per month, 12 hours per day, double coverage with physician assistants. Interested candidates may apply in confidence to Fred W. Knoch, III, MD, FACEP, 445 Kittiver Court, Neenah, WI 54956;414-725-4639. p7-9/91

Internal medicine. The Racine Medical Clinic a 42-physician multi-specialty group conveniently located between Chicago and Milwaukee. Well-equipped all new clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to: RD Lacock, Administrator, Racine Medical Clinic, 3807 Spring St, Racine, WI 53405. 7tfn/91

Wisconsin. Third BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 7-9/91

Wisconsin. Two young BC internists are seeking a third BC/BE internist for well-established, rapidly growing practice located in pleasant central Wisconsin University town of 30,000. Ideal practice opportunity with equal balance of consultative and primary care; well equipped 120-bed hospital, 12-bed ICU. Comprehensive benefit package includes first year salary guarantee, full malpractice insurance and partnership buy-in after one year. Send CV to: Stevens Point Internal Medicine, SC, 3504 E Maria Dr, Stevens Point, WI 54481. p6-9/91

Lake Mills Medical Center, SC

One or two Family Practitioners wanted, board certified or eligible. This is a golden opportunity in an ideal setting, located between Madison and Milwaukee on beautiful Rock Lake in a growing community. A modern, fully equipped hospital close by with full specialty backup but no restrictions to the well trained practitioner. Please call Lake Mills Medical Center, SC, c/o Dr. James P. Wishau, phone (414) 648-2391, for further information. 9-10/91

Physicians Exchange

Continued

Family practice Minnesota. Physician needed for broad based practice in exceptional rural community. Shared call, fully equipped and staffed office, outstanding hospital, excellent guaranteed compensation, full benefits, and bonus. **Family practice Wisconsin.** Multi-specialty group of 16 physicians seeks BE/BC physician for partnership. Less than one hour from metro area. For this and other opportunities in the upper midwest, send CV to Mary Jo Cordes, MDsearch, PO Box 21507, St Paul, MN 55121 or call 612-454-7291. 6-9/91

Community of 2,000, 50 miles NE of Minneapolis/St Paul, seeks additional family practitioner. Located on the St Croix River and Minnesota border. Practice consists of 13 family practitioners, 2 internists, 2 general surgeons and 1 orthopaedic surgeon. Many specialists available on a part-time basis. Attached to a 90-bed hospital with comprehensive services available. Very stable medical group with pleasant working conditions in a continuous growth mode. Guaranteed first year salary with second year partnership. Fringes include excellent retirement package and car. Contact Lenny Libis, administrator at 715-483-3221. 4-9/91

Family practice-hospital-sponsored clinic opportunity..Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking family physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is signifiantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangsness, Associate, The Chancellor Group, Inc, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 1tfn/91

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We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary incentive bonus, plus paid health, life, malpractice, 401K. Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

Internist needed to join one of the leading internal medicine practices in Kenosha, Wisconsin. This is an opportunity to build a strong and vibrant practice within the first one to two years. Office conveniently located on the hospital campus. Kenosha provides an excellent quality of life: many choice yet affordable places to live, superior schools, proximity to recreational facilities, and central location less than one hour from either Chicago or Milwaukee. Compensation competitive including an incentive plan which provides enhanced earning potential. Contact Jan Channon (708) 945-7717 or send CV to 1855 Deerfield Road, Suite 2300, Highland Park, IL 60035. 7-9/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, surgery/vascular, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

Rice Clinic Medical Center

Central Wisconsin. The Rice Clinic, a 29-physician multi-specialty group is seeking BC/BE individuals in the following specialties: family practice, internal medicine, neurology, psychiatry, general surgery, nephrology, oncology, and rheumatology. Attractive income and ownership arrangements. Excellent practice environment with many outdoor recreational and cultural amenities. Send CV to: Paul R. Ford, Administrator, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481 or call collect: 715-344-4120. 7-9/91

Physicians Exchange

Continued

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

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Beloit Clinic, SC, an expanding 45 physician, multi-specialty group in southern Wisconsin college town, is seeking a plastic surgeon, pulmonologist, a rheumatologist, an OB/GYN, and orthopaedic surgeon, a pediatrician, a physiatrist, and urgent care. Guaranteed salary with incentive, plus excellent fringe benefits. Send CV to James F. Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 8-10/91

SE WISCONSIN. Third BC/BE Obstetrician/Gynecologist needed to join single specialty, fee for service laser equipped practice. This two female physician, three nurse practitioner office is located in a desirable suburb close to Milwaukee and Chicago. Excellent quality of life and outstanding recreational area. Attractive financial package including early partnership opportunities. For further information please contact: Lynn Breuggeman, Women's OB/GYN Care, 210 N.W. Barstow Street, Waukesha, WI, or call 414-544-4400. 8-9/91

Medical Meetings-Continuing Medical Education

October 10-13, 1991; American Society of Internal Medicine 35th Annual Meeting at J.W. Marriott Hotel, Washington, DC. Category 1 CME credit will be available. Info: Lisa Derby at 202-289-1700, ext 615. g6-9/91

October 13-17, 1991: 1991 joint meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology at the Anaheim Hilton and the Anaheim Marriott in California. Info: Meetings Department, American Academy of Ophthalmology, PO Box 7424, San Francisco, CA 94120-7424. g3tfn/91

October 28-31, 1991: A Primary Care Update, the Scientific Assembly of Interstate Postgraduate Medical Associationat the Hyatt Regency, New Orleans, Louisiana. Accredited by ACCME and eligible for 24 hours of Category 1 credit of the AMA/PRA. Info: IPMA, PO box 5474, Madison, WI 53705; ph 608-257-1401. 9tfn/91

December 11-13, 1991: "Neurology for the non-neurologist," at The Westin Hotel, Chicago, Ill. Contact: Office of Continuing Medical Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago, IL 60612; ph 312-942-7095. 9-10/91

AMA

December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.

General surgeon, Amery, Wisconsin. Apple River Hospital and Family Medical Clinic have an excellent opportunity available for a general surgeon to join nine-family physicians and an internist in a well-established, progressive group. Come fish, ski, and swim in beautiful Amery; the community is graced with three lakes and the famous Apple River, all located within the city limits! This opportunity is able to offer the best of both worlds: a challenging practice combined with a quality of life your entire family will appreciate. Contact: Loriese A. Stoll, Ramsey Clinic, 640 Jackson Street, St Paul, Minnesota 55101; ph 612-221-3067. 7-9/91

Medical Meetings-Continuing Medical Education

June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

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Wisconsin Medical Journal

The children are our future

October 1991

Into The Woods–Ruffed Grouse
An Owen Gromme Masterpiece

Under an exclusive license with Owen Gromme, Stanton & Lee is selecting unpublished masterpieces from the artist's best years to be released as limited edition prints.
Into the Woods is a special, historical, limited edition print authorized by Owen Gromme.
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I remember the last time Owen Gromme and I walked down this road. We talked about the never-ending thrill of going into the woods. . . .

Mark E. Lefebvre, Publisher

When the history of wildlife art in this century is written, Owen Gromme will be at the forefront and he will be best remembered for his ruffed grouse paintings. *Into the Woods* is one of his finest, created in 1970 when he was at the peak of his career. Owen Gromme chose his son's farm as the setting for this exciting and evocative painting. We are drawn into the woods both by the road and by the ruffed grouse in flight. It is a magnificent autumn day.

To relive this day, to walk Gromme's road and to avoid disappointment, please order now; orders will be filled on a first-come, first-served basis. The print is available *only* through Stanton & Lee, at the Stanton & Lee Gallery in Madison, The Gromme Gallery in Milwaukee, by mail order or toll-free telephone order.

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Contents

October 1991 Vol. 90 No. 10

Opinions

567 *President's page*
'Medicina nusquam non est' (medicine is universal): V
by Cyril M. "Kim " Hetsko, MD, Madison
568 *Secretary's report*
Reform and reality
by Thomas L. Adams, CAE, Madison
570 *Editorials*
You asked for it
by Jeffrey H. Lamont, MD, Wausau
574 *Letters*
A note of thanks
by Haywood S. Gilliam, MD, Madison
574 *Soundings*
Moonlighting
by William Houghton, MD, Milwaukee

Scientific

577 Evaluation of patients with atypical results of a Papanicolaou smear
by Charles W. Schauberger, MD; Jerome H. Gundersen, MD; Donald P. Jensen, MD; Paul L. Felion, MD; and Kenneth L. Merkitch, MD, La Crosse
581 Hyperkalemia from blackstrap molasses
by Mark K. Belknap, MD, Ashland
582 High total dose 5-fluorouracil treatment during pregnancy
by Robert Dreicer, MD, and Richard R. Love, MD, Madison
583 The problem of recurrent stenosis following carotid endarterectomy
by Hope S. Maki, MD; Robert A. Kruger, MD; and Marvin E. Kuehner, MD, Marshfield

Socioeconomic

587 Wisconsin's lobbying law
by Sally Wencel, JD, SMS staff attorney
591 *Public health*
Identifying women who have never had a mammogram
by Paula M. Lantz, MA; Patrick L. Remington, MD; and Eleanor Cautley, MS, Madison
593 A report on budget vetoes affecting health care issues
593 Wisconsin physicians respond to HCFA in record numbers
597 Rules on wearing special equipment in high school athletics

Organizational

599 The children are our future
by Marlene A Scott, assistant editor
602 New PartnerCare cards
602 Employer health care coalitions
604 SMS questions state Medicaid report
604 Adams elected to national board
606 SMS secretary-general manager heads north
607 Physician briefs

Our cover: "Portrait of a Little Boy," by Peter Paul Rubens. Dr Daniel Shea, president of the American Academy of Pediatrics talks of children and the future on page 599.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

'Medicina nusquam non est' (medicine is universal): V

THE HEALTH OF THE CITIZENS of Wisconsin recently received very high marks in an analysis published by a major life insurance company in another state. This study not only looked at items such as our very low infant mortality rate and long life expectancy, it also evaluated factors such as the use of seat belts, automobile fatality rates, the availability of physicians and health care institutions, and public expenditures on health. The study confirmed what we already knew and ranked Wisconsin No. 5 among all states and the District of Columbia.

In spite of the fact that Wisconsinites may not always use seat belts, may drink too much alcohol, or may smoke too much, the citizens of this state should take pride in the excellent health that we enjoy. At the same time, we physicians would like to see our ranking moved from No. 5 to No. 1 in the country, and our profession is concerned about the unevenness and lack of access to our excellent health care system that exists in certain parts of this state, both urban and rural.

The AMA, the SMS, and a number of other groups have come forward with varying proposals to deal with some of the inequities in health care distribution while taking into account the explosive increases in health care costs. These proposals need genuine consideration. In implementing any changes to the system, however, we must be vigilant in protecting from harm the excellent health care system that Wisconsin already enjoys.

As I quoted Sam Rayburn earlier this year, "Any jackass can kick in a barn door, but it takes a carpenter to build one."

Some proposals call for greatly expanded state and federal government roles in either running the health care system or acting as a single, massive purchaser of services. A conflict has arisen in this state and across the nation between the increasing costs of health care and the perception of diminishing resources to pay for them.

It may seem odd that, at a time when we praise the inevitable demise of the centralized economies of Eastern Europe and the Soviet Union in favor of market economies, some in this country would want a single-payor national health system. With the examples in this country of Amtrak, the postal service, Medicare, and Medicaid, we must be wary of more centralized government control, which stifles original thought, inhibits innovation, and leads to misallocation of resources.

We all know that the federal government since the 1960s, Congresses and presidents included, have created the promise to the American people that when they get old the government will take care of their health care needs. This proves to be a very hollow promise every time they come up with a new service that they will not cover, every time they come up with a new punitive PRO mechanism to arbitrary and capriciously decide what is unnecessary care, and every time they come up with systems like DRGs and RBRVS cutbacks to ratchet down payments. The state and federal governments are again reneging on their promises.

Cyril M. "Kim" Hetsko, MD

We must be wary of some of the dangers of rationing and price con-

Continued on page 572

Secretary's report

Reform and reality

FOUR YEARS AGO, I stood before the SMS House of Delegates and talked about the plight of Wisconsin's uninsured population. I said they would soon become the leading political issue in medical circles, and I called for mandated employer-provided health insurance. At the time, those ideas were considered radical; today, they may be evolving into a public consensus. In January 1991, 76% of the respondents to a Gallup poll of Wisconsin support the idea of employer-based health coverage. That is surely a sign of progress, in the public's understanding of the problem if nothing else.

The Wisconsin Manufacturers and Commerce joined with the SMS and the Wisconsin Hospital Association to work out a broad agenda of health care system reforms that would be both acceptable in the political world and workable in the real world. The 12-point plan that was created does not call for mandated employer-provided coverage, but it does assume that most employers want to insure their employees and seeks to enable employers that cannot now do so to obtain affordable coverage. Meanwhile, the universal health care proposals have continued to attract a significant level of attention from the news media, elected leaders, and the public. At this point, that's to be expected. Dreams are far more attractive than plans of practical application; or, as former SMS President JD Kabler has observed, "How you stand depends on where you sit."

Very shortly, however, push will come to shove and the pressure of the uninsured population's suffering will force all of us would-be reformers to answer the question: "OK, how will you do it?" Those who are advocating a system overhaul to provide every man, woman, and child first to last dollar coverage for, and immediate access to, every known drug and treatment will have no good answer. This being an imperfect world of finite resources, such a system will most likely remain a utopian dream.

But a sick or injured person with no health insurance will find little comfort in a dream. In contrast, the accompanying table provides at a glance the difference between what 450,000 uninsured Wisconsin residents have now and what they would have under the plan developed by a coalition of the SMS, the WHA and the WMC. Does it provide universal first dollar coverage? No. But insurance was never intended to do that.

Thomas L. Adams, CAE

The plan is, admittedly, a modification of the existing health care delivery system and a long way from utopia, but it does provide something to those who now have nothing. It does provide for everyone's basic needs. What's more, it works within the basic framework of a system that currently serves roughly 89% of America very well. The plan will, admittedly, invoke the dreaded *T*word--taxes--but Wisconsin's residents (69%) have said they are willing to pay more to provide for the uninsured and the cost of this plan is infinitely less than the cost (in both dollars and freedoms) of utopia.

I've urged you before, but I'll do it again: Talk to your patients. Explain to them the risks. In the words of the immortal bard: Action is eloquence.❑

Health care benefits for Wisconsin's 450,000 uninsured residents:

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Editorials

You asked for it

REMEMBER FIGHTING with a brother or sister when you were a kid? Maybe they were like the disagreements I used to have with my brother, Greg.

The arguments always seemed terribly important at the time, and there was never any room for compromise on either side. They usually centered on things like who would get to ride in the front seat, who would get the last piece of cake, whose turn it was to watch what program, or who was responsible for trashing the basement. The arguments and name calling would become more strident and vicious.

Eventually, Mom or Dad would issue the 2-Minute Warning. In our house, the 2-Minute Warning usually consisted of three things: a reference to our lack of maturity ("Will you two act your age?!"); a brief mention of parental tolerance ("I've had it up to here with you two!" usually accompanied by a knife-edged hand held at chin level); and a suggestion concerning amicable resolution of the point under debate ("Settle it between yourselves or else.").

Of course, at that point, my brother and I were each suffused with wounded pride and righteous indignation, and compromise was absolutely out of the question. At this point, mom or dad would step in and impose the Solution.

Now, the Solution was characterized by three things: it was harsh, it almost never had anything to do with the original question under discussion, and it was final. For example, an argument over television programming could end with my brother and me being assigned to clean the basement. Protests at the injustice of it all usually did little but to remind my folks that the garage could stand cleaning out, as well.

The funny thing was, Greg and I

Continued on page 572

Peppino's

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AIR FORCE

Continued from page 570
never seemed to learn. The pattern of argument, 2-minute warning and solution became predictable in its regularity, and yet my brother and I could not see in ourselves the selfishness that our parents could see all too clearly.

I was reminded of these *contretemps* recently, when I attended a conference hosted by Rep Jim Moody concerning the future of health care in America, particularly its cost and availability. Five interested parties were identified: the consumer, the provider, the insurer, business, and the government. Of these five, the government will probably end up playing the lead role, inasmuch as any major change in the structure of health care provision or financing will likely come through legislation.

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Gail Wilensky, PhD, chief of the Health Care Financing Administration (and not the most popular person in physicians' circles right now, *vis-à-vis* RBRVS), gave her perspective of the health care crisis, as did Rep Moody and Rep Pete Stark of California. Their views as to a solution to the problem differed in several ways, but one central theme was repeated, and that was that any meaningful solution to the problem of health care accessibility and financing would require compromise on all sides.

At the end of the day, I left the meeting wondering how much compromise there would be and when it would come. Business representatives complained that, as major purchasers of health care, they had too little to say about what they were buying and how it was used. They decried the failure of the system to apply "sound business principles" to the administration of health care. Several factions, led by representatives of the health insurance industry, took to bashing universal access health care as practiced in other countries. These representatives gave the distinct impression that they thought the insurance situation in this country was certainly no worse, and in some ways better than anywhere else. Everyone blamed someone different–even consumers were blamed for not doing more to keep themselves healthy.

The problem, of course, is that all concerned parties do, in fact, share in the responsibility for the success or failure of our health care system. Each group–consumers, providers, business, insurers, and government–has been giving and getting 2-Minute Warnings. Without compromise, there is no doubt that, within 10 years, a final Solution will be imposed on us all–and if it is more harsh, unfair and ruthless than we would like, we will have only ourselves to thank.

As my parents would have said as they snapped off the TV and pointed to the basement, "You asked for it."

–Jeffrey H. Lamont, MD
Wausau❑

Continued from page 567
trols. Historically, price controls have not worked, except for extremely short periods of time such as in World War II, and certainly rent controls in New York City have had long term disastrous effects.

Government does have a role in making sure that the playing field is level and that a fair and competitive marketplace can exist. Additionally, the government has a role in assuring its citizens that safety nets exist so that at least basic health care access and benefits are available to all.

Such governmental roles might include: the elimination of health care underwriting for health insurance; the mandating of basic health insurance benefits for all employed people (including the government's own "limited term employees" for whom no benefits are now provided); the prohibition of fiscally unsound health benefit programs for the employees of self-insured businesses; and the elimination of the exemptions of these self-insured programs from contributing to the state-run high risk pool for those unable to purchase health coverage elsewhere.

In discussing the future role of government in the health care system, we should keep in mind two basic traits of our citizens. Americans tend to want the best. And Americans tend to want it now. A marketplace with a level playing field and safety nets available may be the best way of achieving these goals. We must keep in mind the basic and inherent distrust that Americans have of government.❑

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Letters
A note of thanks

TO THE EDITOR: I wish to thank the members of the SMS for honoring me and all those members who served as a part of Operation Desert Storm with the Presidential Citation for the year 1991.

I am truly honored to be recognized by the SMS in this way, and will cherish the award always. I am not sure that my personal contribution was worthy of such designation, but certainly many of those who served did this with distinction and a great hardship. The Society's kindness and the attention of the country has more than repaid us all for our participation during a difficult and challenging time.

Again, thank you very much for bestowing this award upon me personally and upon all involved participants in general. This action reflects positively on the State Medical Society of Wisconsin.

–Haywood S. Gilliam, MD
Madison❑

Soundings
Moonlighting

(By an extraordinary quirk of the space-time continum, these notes were recently discovered on a diskette in a writing box. They appear to be part of a letter or journal kept by an old-fashioned internist who practiced in the United States in the early decades after 2000 AD.)

I DID INSURANCE PHYSICALS and ER work before I started the graveyard shift at Whispering Pines. Whispering Pines paid $500 a pop, and I quickly grew to like the calm and quiet and efficiency there, after the frenzy of the ERs, with gunshot wounds, screams, and code blues.

Whispering Pines was calm and peaceful, a 1-story, red brick, small ranch-style hospital, perched on a hillside. There was a row of pines out back.

I walked in the doctor's lounge, tossed my bag in the locker, put on my greens, and did a quick scrub–they were never fussy about scrubs, but not sloppy either–and went into the OR. Some guys wore masks; I never did.

They had a reception area off the OR, and most nights there were four or five oldsters lined up on carts, the ones that the committee already passed on, and certified for euthanasia. Most of them were gorked out, senile or wasted away, quite a few over 100 years old, and they just lay there, a little pile under the sheets, practically invisible. Some were awake, some were even sort of alert, and some of them had relatives in to pay respects and say goodbyes.

The nurse wheeled them into the OR, she alcohol-scrubbed their arms and stuck in the IV, and I slipped them 60 mg of morphine sulfate. They slept away, we ran a rhythm strip and in a flat-line brain wave, and the morticians picked them up at the back door.

It was all peaceful and efficient. The oldies were happy, the relatives were happy, and the staff was happy. Ever notice how people helping old folks are always cheerful? At $500 a

Continued on page 576

Opinion policy

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Continued from page 574
pop, four or five cases a night, one or two hours a shift–remember these were 2012 A.D. dollars–me and my $200,000 of medical school loans were happy too.

Some of my colleagues didn't like it too much, I got a few cracks over at St. Mary's, but I told them; "Who pays for you? I'm just taking care of me and mine, following the law."

So everything was copasetic for a couple of years, Whispering Pines and me were doing more business, until after awhile it gradually got boring, and then worse.

Part of it was the stage I was at. I was building up my practice, got my cardiology boards, and I joined the Riverside Medical Group, which was expanding all over the place. We were busier than we knew what to do with, so I cut back my hours at Whispering Pines.

Jane and I had four kids by then, all in a bunch. I felt I was buried in life, it was swarming all over me, and then I started to get the hang of it, and I was swimming on top.

I started to notice the people I was treating, the kind of folks they were, and I just couldn't help caring about them. I mean, I never went too far with that, I didn't get overly involved, but somehow they worked their way into me, and sometimes I would think of them after hours. Things kind of mix together as you get older.

One example I can think of was this bouncy salesman I saw, 35 years old, he was always sucking a soda and munching chips, and–bang!–he had a massive coronary. He was at death's door. We worked him up and did a triple bypass, and we pulled him through. I really wanted that Bohunk to make it, and I was pleased to see him sucking soda and munching chips again, even if it wasn't the ideal diet.

It was not the occasional mixups over at Whispering Pines that did it, for me, though I thought about them too. You've probably read in the papers about the committee certifying the wrong patient, getting the records or the data mixed up, and cooling the wrong person. But that's a media horror story, *International Enquirer* stuff. We had our goof-ups, but I doubt we ever got the totally wrong person. The ones we got, they all had some reason to die. Even if there was an occasional mistake, every procedure has a certain risk of side effects, and that doesn't disprove the principle of euthanasia.

One of the real problems I worried about was the interpretation of the data, and who does it. You could have guy with a fatal disease, a kosher living will, the family is all in chorus and standing by the certified patient, but then the guy waivers in his intention, and who knows what he wants? Some of these guys were pretty alert, and when we put in the IV they said they weren't sure if they wanted to do it. The nurse would usually chat with them a bit, she didn't hurry them, and then they'd nod their head and take their medicine. You can say it's the clutch of a drowning man, but it worked on me, and I had some bad dreams of faces slipping away, sliding off and fading out.

The clincher was this leukemia kid I was treating in my regular practice. It was a 6-year-old boy in a family where I took care of everyone else. I usually don't do kids, but the family asked me to look in on him, and the oncologist ran him through the chemotherapy. The kid was doing great, and then he had a setback and turned kind of blue and frail. I don't have to tell you how a kid like that fights to live, actually assumes he's going to live 'cuz he doesn't know any better, and I found myself stopping in his room twice a day to kid around with him, and I couldn't stop thinking of him after hours, I wanted him to pull it off so bad.

It came time to do my next stint at Whispering Pines, and I couldn't do it. I'd lost my heart for it.

I told them my schedule was tight--they got some young grad or old boozer to do it–but that wasn't the explanation.

The principle of euthanasia is perfectly fine, but things mix together when you're older. I'm a black-and-white, meat-and-potatoes kind of guy, and if I'm not rooting for life in the day, I can't switch over and help death in the evening. Not if I'm sleeping sound and getting up for my real practice the next day. The emotions won't take it. You can take the specs on a disease, get the body certified and write an ironclad contract, do the procedure smooth as silk. You can do a rhythm strip and a brain wave, but have you got a meter for hope? The emotions just can't take it, not the emotions of the doctor, and not the emotions of the people. We're going to have to evolve further, a lot further. That's what I really think.

But I told the people at Whispering Pines my schedule was booked, and they were very decent about it. They gave me a top-of-the-line Rolex watch.

–William Houghton, MD
Milwaukee ❑

Evaluation of patients with atypical results of a Papanicolaou smear

Charles W. Schauberger, MD; Jerome H. Gundersen, MD; Donald P. Jensen, MD; Paul L. Felion, MD; and Kenneth L. Merkitch, MD, La Crosse

One hundred women with atypical Papanicolaou smear results were examined in a protocol of colposcopy, cervicography, cervical cultures, and wet preparations of vaginal secretions. Infections of the vagina and cervix were rare and often found in patients with coexistent cervical dysplasia. Cervicography identified many of the patients who ultimately were found to have cervical dysplasia but had high false positive and false negative rates. Forty-seven percent of the patients had cervical dysplasia or cervical condyloma. Based on this high rate of dysplasia, treatment of vaginitis and repeated cervical cytology cannot be recommended. Colposcopy represents the most appropriate approach to the patient with atypical cytology. *Wis Med J* 1991; 90(10):577-580.

Numerous reports have addressed the issue of whether patients with atypical Papanicolaou smear results should be referred for colposcopy or undergo a repeat Papanicolaou smear. Sandmire et al reported a high incidence of severe dysplasias and carcinoma in patients with atypical Papanicolaou smear results.[1] The results of many research studies have supported the use of colposcopy,[2-8] but some authors still advise repeating Papanicolaou smears in 3 months or treating vaginitis as an alternative to colposcopy.[9] Many practitioners still follow these latter recommendations.

The number of abnormal Papanicolaou smear results continues to increase as the human papilloma virus (HPV), a probable etiological agent or cofactor for dysplasia, is increasingly identified in the sexually active population. Concerns about high false negative rates for Papanicolaou smears may be causing some pathologists to call "borderline" Papanicolaou smear results atypical more often. These factors combine to make the incidence of the atypical result higher.

Efforts to treat the cause of an atypical Papanicolaou smear result by treating any vaginal infections and repeating the Papanicolaou smear after treatment have had mixed results. Mecsei et al found chlamydia in 7.2% of their patients with cellular atypia on Papanicolaou smear. The smear results reverted to normal in 18 of 23 patients treated with tetracycline. Their patients did not undergo colposcopy to determine the rate of false negative Papanicolaou smear results.[10] Ridgley et al repeated Papanicolaou smears for those patients with atypical results in 4 months and found a significantly greater occurrence of vaginal infections in the patients who had repeat abnormal results.[11] Reiter found that treatment before repeat cytology did not improve the rate of reversion to normal cytology.[12]

Cervicography was developed by Adolf Stafl, MD, as a screening tool for cervical intraepithelial neoplasia (CIN) in 1981. The cerviscope is a special camera with a macrolens and ring strobeflash. The cervigram is a 35 mm slide taken after cleansing the cervix with 4% acetic acid. The film is developed by a centralized laboratory and the slide evaluated by specially trained and experienced colposcopists. Cervicography is not difficult to perform, adds only several minutes to the examination and is inexpensive (approximately $50). Its greater sensitivity makes it a valuable tool for the detection of cervical dysplasia. It has also proved to be an invaluable tool for documentation of

Dr Schauberger, Dr Gundersen, Dr Jensen, Dr Felion, and Dr Merkitch are from the Colposcopy and Cervical Pathology Clinic at the Gundersen Clinic in La Crosse. Funding for the study was provided by the Gundersen Medical Foundation of La Crosse. Reprint requests to: Charles Schauberger, MD, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Copyright 1991 by the State Medical Society of Wisconsin.

Table 1.–Protocol for evaluation of atypical Papanicolaou smear results (Class II).

Cultures
gonorrhea
chlamydia
Wet preparation for identification of:
yeast infections
clue cells
Cervicography
Colposcopy

Table 2.–Bacteriologic and colposcopic findings at the time of colposcopy and examination.

gonorrhea	0
chlamydia	5
yeast infection	6
bacterial vaginosis	3
condyloma without dysplasia	11
CIN 1 (mild dysplasia)	25
CIN 2 (moderate dysplasia)	7
CIN 3 (severe dysplasia)	4

colposcopy findings.

Certainly cervicography could be very valuable if it could help triage the patients with atypical Papanicolaou smear results into those who had no significant lesions and those who needed colposcopy. Spitzer et al reported using cervicography to direct those patients with cervical lesions to colposcopy. A high number of significant lesions (55%) that required colposcopy anyway and the problems of poor patient compliance caused them to reject cervicography as a triage technique in their patient population.[5]

Jones and Creasman found a 25% rate of CIN with cervicography identifying 81% of the lesions. They concluded that neither colposcopy nor cervicography represented ideal intermediate screening procedures, but both were superior to Papanicolaou smear repetition.[6] August felt that cervicography represented a successful and cost-effective method of intermediate case finding in patients with atypical cytology.[13]

This study represents a review of 100 patients evaluated by a protocol to evaluate cervicography, cervical STD cultures and wet preparation evaluation as initial evaluation of atypical Papanicolaou smear results.

Methods

A protocol for the evaluation of atypical (Class II) Papanicolaou smear results was developed for patients seen at the Colposcopy and Cervical Pathology Clinic at Gundersen Clinic (Table 1). Evaluation was performed by the authors over approximately 2 years, beginning in the fall of 1986. The patients were not necessarily consecutively entered into the study. This study represents a retrospective review of the first 100 patients who met the criteria of the study by the fall of 1989.

Patients were cultured for gonorrhea and chlamydia in the usual manner from the endocervical canal. A wet preparation was performed from the vaginal pool for identification of candidal vaginitis, trichomonas and bacterial vaginosis. A cervigram was performed using the usual protocol as devised by Stafl. Colposcopy was performed in all patients with directed biopsies being performed of suspicious lesions. The cervigrams were all reviewed by a single examiner who was blinded to the culture or colposcopic findings at the time of the review.

The data was entered into the clinic's IBM personal computer with a customized Dbase III program and a statistical package for tabulation of data and statistical analysis.

Results

The bacteriologic and colposcopic findings are summarized in Table 2. One hundred patients met the criteria of the study, with 93 patients having had adequate cultures for gonorrhea and 94 having adequate cultures for chlamydia. Only five patients had positive chlamydia cultures. There were no positive gonorrhea cultures. Six patients had evidence on wet preparation and on examination of having candidal vaginitis, and three patients had evidence on wet preparation of having bacterial vaginosis. Three of these patients also exhibited signs of HPV infection or dysplasia on colposcopic examination.

Eighteen patients had positive cervigrams, 41 were atypical, and 39 were negative. There were two technically defective cervigrams. Table 3 represents the biopsy data for each of these groups. Forty-seven of the 100 patients had histologic evidence of CIN or HPV on biopsy.

Discussion

The infrequent presence of organisms associated with vaginitis or cervicitis is a prominent finding of this study. Microbiological assessment proved to be of very limited value in the assessment of Class II Papanicolaou smear results. There is a recognized public health value in screening sexually active females for gonorrhea and chlamydia at the time of a pelvic examination, but it cannot be recommended as an evaluation technique for atypical Papanicolaou smear results. Likewise, treatment of a patient with an atypical Papanicolaou smear result with sulfa creams and repeating the Papanicolaou smear in 3 or 6 months usually just delays the eventual colposcopic examination and risks the possibility of the patient having a false negative Papanicolaou smear.

The low rate of gonorrhea or chlamydia infection in this patient group reflects the low rate of these pathogens in our patient population. Furthermore, the presence of yeast infections or bacterial vaginosis was often accompanied with significant colposcopic findings, drawing into question the likelihood that those

infections were even partially responsible for the atypical Papanicolaou smear results.

Cervicography did prove to be somewhat sensitive in identifying 61% of the cervical lesions that were proven significant at the time of colposcopy. Unfortunately, this relatively new methodology is plagued by a high incidence of false positive findings.[5,6,13-15] This was also the case in this study. Adjustments in the reading and reporting methods in the last year will, we hope, improve the identification of patients with trivial lesions that do not require colposcopy. Furthermore, research into the significance of positive cervicography findings with negative pathology may help us to determine the causes and significance of these findings. The technically defective rate of 2% is very low and usually obtainable as experience with this technique increases.

The high rate of dysplasia found at time of colposcopy was quite significant. This agrees with the previously cited literature. A compilation of available studies is listed in Table 4. It is our assessment that the rate is so high that the use of an intermediate screening technique such as cervicography cannot be justified in all cases for the evaluation of atypical Papanicolaou smear results. It remains primarily a valuable screening tool in conjunction with the Papanicolaou smear. It is our recommendation, therefore, that all patients with any degree of atypia or dysplasia on Papanicolaou smear should be referred for colposcopy. The technique of repeating the Papanicolaou smear or treating for cervicitis or vaginitis is counterproductive in many cases, since it delays the eventual evaluation by colposcopy of significant lesions.

Table 3.–Comparison of pathology in patients with suspicious *v* negative cervigram.

	Positive cervigram (n=50)	Atypical cervigram (n=41)	Negative cervigram (n=39)
condyloma	4	3	4
CIN 1	5	11	9
CIN 2	2	3	2
CIN 3	0	1	3

References

1. Sandmire H, Austin S, Bechtel R. Experience with 40,000 Papanicolaou smears. *Obstet Gynecol.* 1976;48:56-60.
2. Tay S, Jenkins D, Singer A. Management of squamous atypia: repeat cytology or colposcopy? *Aust New Zealand J Obstet Gynecol.* 1987;27:140-141.

Continued on next page

Abstract

Incidentally discovered adrenal masses

Robert H. Caplan, MD; William A. Kisken, MD; and Christopher M. Huiras, MD (*Minn Med* 1991;74:23-26).

THIS REPORT DESCRIBES a retrospective study of 23 patients with incidentally discovered adrenal masses. Two patients with subclinical cortisol secretion developed adrenal insufficiency after removal of benign adenomas. Another patient, who probably harbors an asymptomatic pheochromocytoma, developed a hypertensive crisis when a mass was palpated during aortic vascular surgery. Twelve patients underwent surgery. Seven benign adenomas, an angiomyolipoma, and a cyst were removed. Three patients had malignant masses that included an angiosarcoma, an adrenal adenocarcinoma, and a congenital neuroblastoma.

We conclude that hormones, especially cortisol, may be secreted in subclinical amounts by incidentally discovered masses. We recommend a concise laboratory evaluation that includes an overnight dexamethasone suppression test. Based on our interpretation of the literature, we believe masses greater than 3 cm in size should be removed. Patients who do not undergo surgery should have computed tomographic scans repeated for 1 year and should be reassessed periodically for the development of hormone secretion.❑

Continued from preceding page

3. Morrison B, Erickson E, Doshi N, et al. The significance of atypical cervical smears. *J Repro Med.* 1988;33:809-812.
4. Maier R, Schultenover S. Evaluation of the atypical squamous cell Papanicolaou smear. *Int J Gynecol Path.* 1986;5:242-248.
5. Spitzer M, Krumholz B, Chernys A, et al. Comparative utility of repeat Papanicolaou smears, cervicography, and colposcopy in the evaluation of atypical Papanicolaou smears. *Obstet Gynecol.* 1987;69:731-735.
6. Jones DE, Creasman WT, Dombroski RA, et al. Evaluation of the atypical Papanicolaou smear. *Am J Obstet Gynecol.*1987:157:544-549.
7. Busseniers AE, Sidawy MK. Inflammatory atypia on cervical smears. A diagnostic dilemma for the gynecologist. *J Repro Med.* 1991;36:85-88.
8. Lindheim SR, Smith-Nguyen G. Aggressive evaluation for atypical squamous cells in Papanicolaou smears. *J Repro Med.* 1990;35:971-973.
9. Brown M, Phillips G. Management of the mildly abnormal Pap smear: A conservative approach. *Gynecol Oncol.* 1985;22:149-153.
10. Mecsei R, Haugen OA, Halvorsen LE, Genital *Chlamydia trachomatis* infections in patients with abnormal cervical smears: Effect of Tetracycline treatment on cell changes. *Obstet Gynecol.* 1989;73:317-321.
11. Ridgley R, Hernandez E, Cruz C, et al. Abnormal Papanicolaou smears after earlier smears with atypical squamous cells. *J Repro Med.* 1988;33:285-288.
12. Reiter RC. Management of initial atypical cervical cytology: A randomized, prospective study. *Obstet Gynecol.* 1986;68:237-240.
13. August N. Cervicography for evaluating the "atypical" Papanicolaou smear. *J Repro Med.* 1991;36:89-94.
14. Blythe J. Cervicography: A preliminary report. *Am J Obstet Gynecol.* 1985;152:192-195.
15. Gundersen JH, Schauberger CW, Rowe NR. The Papanicolaou smear and the cervigram. A preliminary report. *J Repro Med.* 1988;33:46-48.❑

Table 4.–Numerous studies on the frequency of dysplasia at colposcopy in patients with inflammatory atypia.

Reference	No. of patients	No. with dysplasia (%)
Tay et al[2]	44	33 (75)
Morrison et al[3]	139	35 (25)
Maier et al[4]	429	86 (20)
Spitzer et al[5]	97	15 (15)
Jones et al[6]	236	58 (25)
Busseniers et al[7]	70	12 (17)
Lindheim et al[8]	101	30 (30)
Reiter[12]	110	49 (45)
August[13]	1,217	186 (15)
Current study	100	36 (36)
Total	2,543	490 (19)

WMJ Writing Contest

Awards: $500, publication in the *WMJ*, and presentation of a certificate at the SMS annual meeting. Two awards are granted: one student, one resident.

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Criteria: scientific merit, applicability, content, innovation and writing ability.

Contact the *WMJ* for further details.

Hyperkalemia from blackstrap molasses

Mark K. Belknap, MD, Ashland

A 67-YEAR OLD MAN had a history of coronary artery disease and coronary artery bypass surgery in 1972 and recurrent episodes of supraventricular tachycardia. He had been treated with propranolol 20 mg four times daily and digoxin 0.25 mg daily for several years. The rhythm on his previous electrocardiograms had been sinus.

In September 1989, he saw his physician because of increasing frequency of symptomatic episodes of tachycardia. He was prescribed sustained released verapamil. Approximately 2 hours after he took the first dose, he noted weakness, lightheadedness, and fecal and urinary urgency. He then had a witnessed syncopal episode.

On arrival to the hospital, he was dysarthric and confused. Cardiac rhythm was initially sinus with third degree AV block and junctional escape. His pulse rate was 40 beats per minute and blood pressure was 50/0. Shortly after admission, an electrocardiogram showed profound sinus bradycardia with a rate of 18 and junctional escape rhythm with a rate of 35. With the drop in heart rate, his blood pressure became undetectable. Atropine (1 mg) was given intravenously and his heart rate rose to 40 beats per minute. A junctional rhythm with retrograde conduction was noted, but without improvement in blood pressure. His blood pressure improved with the administration of intravenous fluids and dopamine.

Results of laboratory tests drawn on admission returned with a serum potassium concentration of 7.4 mmol/L, which was repeated and confirmed, and a serum creatinine value of 2.8 mg/dL (248 mmol/L). A previous serum creatinine determination was 1.5 mg/dL (133 mmol/L). Calcium chloride, insulin and glucose, and sodium bicarbonate were administered in sequence.

Within 2 hours after these interventions, the serum potassium level was 5.9 mmol/L. When the test was later repeated, the level was 4.9 mmol/L, and it remained in normal range for the remainder of the patient's hospitalization. With normalization of serum potassium levels, a sinus rhythm with a rate of 60 to 70 was noted. Blood pressure normalized and dopamine was discontinued. Serial electrocardiograms and creatine kinase determinations showed no evidence of myocardial infarction.

Further history was obtained from the patient, who reported daily intake of 2 tablespoons of blackstrap molasses as a tonic. Blackstrap molasses is the residue remaining after the final extraction of sucrose in the processing of sugar cane.[1] Blackstrap molasses contains approximately 15 mEq potassium per tablespoon.[2] After careful history, no other therapeutic source of potassium was discovered.

Cardiac effects of hyperkalemia include alterations in depolarization and repolarization, resulting in QRS prolongation and narrow, peaked T-waves. Hyperkalemia also depresses A-V nodal conduction.[3] The S-A node is relatively resistant to hyperkalemia, but conduction though perinodal atrial tissue may be depressed, resulting in S-A block.[4]

In this patient, insidious onset of renal insufficiency resulted in impaired clearance of an increased dietary potassium load due to chronic ingestion of blackstrap molasses with resultant hyperkalemia. Shock and metabolic acidosis may also have been mechanisms contributing to hyperkalemia. The cardiac effects of hyperkalemia appear to have been potentiated by administration of verapamil. Digoxin and propranolol may have also had depressant effects on sinus node and AV nodal function. Correction of hyperkalemia, however, resulted in prompt correction of the rhythm disturbances within a period when the pharmacological effect of digoxin, propranolol, and sustained-release verapamil would have remained steady. Therefore, it appears that the predominant interaction in this case was a combined effect of hyperkalemia and verapamil, resulting in effective slowing of the sinus rate and in A-V block. The mechanism of sinus slowing is unclear. S-A block as a possible mechanism was not evident on the monitored rhythm. The effect of myocardial ischemia or beta blockade are also considerations. No previous reports of similar effects of combined hyperkalemia and verapamil therapy on cardiac rhythm were found on review of the medical literature.

Blackstrap molasses was implicated as the source of excessive exogenous potassium in this patient. It should be recognized as a rich source of potassium with potential for both therapeutic benefit and toxicity.

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References

1. Zapsalis C, Beck RA. *Food Chemistry and Nutritional Biochemistry.* New York: John Wiley & Sons, 1985:409.
2. Pennington JAT. *Bowes and Church's Food Values of Portions Commonly Used.* 15th ed. Philadelphia, PA: JB Lippencott, Co, 1989:189.
3. Brown H, Tanner GL, Hecht NN. The effects of Potassium salts in subjects with heart disease. *J Lab Clin Med.* 1951;36:506.
4. Fisch C. *Relation of electrolyte disturbances to cardiac arrhythmia circulation.* 1974;47:408.❑

High total dose 5-fluorouracil treatment during pregnancy

Robert Dreicer, MD, and Richard R. Love, MD, Madison

Experience with systemic chemotherapy in the treatment of the pregnant patient with metastatic breast cancer is limited. Most available reports review the use of single agents and those of combination chemotherapy deal predominantly with hematologic malignancies. While 5-fluorouracil (5-FU) is a commonly used antineoplastic agent in the treatment of metastatic breast cancer, there is minimal reported experience with this drug in the therapy of pregnant patients. We report here the birth of a normal infant in a woman with metastatic breast cancer treated with cyclophosphamide, adriamycin and high total dose 5-FU. *Wis Med J* 1991;90(10):582-583.

FIVE-FLUOROURACIL (5-FU) is a synthesized fluoropyrimidine which acts as an inhibitor for the thymidylate synthetase reaction and thereby disrupts DNA synthesis. Five-FU's mechanism of action is complex and is the subject of active investigation. The primary clinical toxicity of 5-FU results from its effects on rapidly dividing tissues, specifically of mucosa, intestine, and bone marrow. The drug is known to penetrate well into the cerebrospinal, peritoneal, and pleural fluids; but there is no information of which we are aware regarding its penetration into the placenta.[1]

In pregnant animals, 5-FU is known to cause multiple fetal abnormalities including intrauterine growth retardation and fetal death in rhesus monkeys, and microphthalmus, omphalocele, and cleft palate in mice.[2,3]

In humans, 5-FU has had minimal reported use during pregnancy. We report here the birth of a normal infant after exposure during second and third trimesters of gestation to cyclophosphamide, adriamycin and a total dose of 19,775 mg 5-FU.

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Case report

A 29-year old pregnant woman developed back pain in her 8th week, and severe right hip pain during her 14th week, and was hospitalized. An abdominal ultrasound study showed a 14-week viable fetus and hepatomegaly with multiple areas consistent with metastases. The results of a CT scan-directed needle biopsy prompted a diagnosis of adenocarcinoma. The patient was transferred to the University of Wisconsin Hospital where her physical examination was significant for a 10x10 cm left breast mass, hepatomegaly, an abdomen consistent with a 14-week pregnancy, and normal mental status. Significant laboratory studies included hemoglobin 10.5 gm/dL, white blood count 9,700/mm^3, serum calcium 18.8 gm/dL, normal electrolytes, serum creatinine 2.0 mg/dL correcting to 0.8 mg/dL after hydration, alkaline phosphatase 269 u/L, SGOT 121 u/L and total bilirubin 0.5 mg/dL. Chest and bone radiographs revealed several lytic rib lesions and multiple lytic lesions in her pelvis and proximal femurs.

The hypercalcemia was treated with saline hydration and furosemide administration. Lengthy discussions about treatment options and their uncertain effects were held with the patient and her family, obstetrical consultants, and the patient's family physician. The patient elected to continue her pregnancy and receive concomitant outpatient chemotherapy. She was treated on a 4-week cycle with oral cyclophosphamide 150mg/m^2 days 3 through 12, adriamycin 50mg/m^2 on day 2, and 5-FU 300 mg/m^2/day continuously via an infusion pump from day 1 through 7, with escalating 5-FU doses each cycle to a maximum of 500mg/m^2/day. Serial blood monitoring studies showed no evidence of placental dysfunction. The patient received a total of 11,000 mg cyclophosphamide, 193 mg of adriamycin and 19,775 mg 5-FU. The patient tolerated therapy well with moderate myelosuppression and fatigue. She had an excellent partial remission of measurable and evaluable disease and control of her hypercalcemia throughout the pregnancy. During the 4th cycle, the patient received 500mg/m^2/day of 5-FU for 7 days and developed mild mucositis and moderated nausea and vomiting. The dose of 5-FU was decreased for the last cycle given during pregnancy, which the patient received 3 weeks prior to cesarean section delivery of a healthy appearing 5lb 14oz boy of estimated gestation 38 weeks.

The newborn had normal complete blood count and chemistry surveys, and developed physiologic jaundice (total bilirubin peaking at 9.6 mg/dL). At 4 months he was in the 50th percentile for height and weight, with normal complete blood count and chemistry surveys, and at 15 and 24 months he remained in excellent health and exhibited normal development. After giving birth, progressive breast cancer developed in the mother. Other cytotoxic therapies were given, but death occurred 16 months after delivery.

Discussion

The optimal and safest therapeutic systemic treatment approaches to pregnant women for several malignancies are undefined. While theo-

retically pregnancy may exacerbate the course of a patient with breast cancer, firm evidence on this speculation is lacking. The majority of patients with breast cancer presenting during pregnancy do not have metastatic disease, and are managed surgically or their systemic therapy is delayed.[4]

Our patient was early in her pregnancy, which she elected to continue, and had life-threatening malignant hypercalcemia at diagnosis. We chose to treat her with a dose-intense regimen because we believed this might increase the chances for control of the cancer and for a successful conclusion to the pregnancy.

We believe that our patient received the largest reported dose of 5-FU during pregnancy. The majority of literature and the normal infant reported here support the concept that chemotherapy administration during the 2nd and 3rd trimesters is associated with a low frequency of fetal abnormalities.[6-8] One report of first trimester 5-FU treatment noted multiple anomalies in the aborted fetus.[9] Until a central reporting system is established, experience with the therapy of pregnant patients with malignancy will require reporting small series of patients. While additional reports of experience with 5-FU as a single agent and in combination will be needed before any firm recommendations for its use during pregnancy can be made, the current case suggests that it can be given in high total doses over 5 months of the second and third trimesters without obvious harm to a developing fetus.

References

1. Chabner BA, Myers CE. Clinical pharmacology of cancer chemotherapy. In: DeVita Jr VT, Hellman SH, Rosenberg SA, eds. *Cancer Principles and Practice of Oncology.* Philadelphia: JP Lippincott Co; 1982:164-166.
2. Wilson JG. Use of Rhesus monkeys in teratologic studies. *Fed Proc.* 1971;30:104-109.
3. Dagg CP. The interaction of environmental stimuli and inherited susceptibility to congenital deformity. *Am Zool.* 1971;3:223-228.
4. Stadler HE, Knowles J. Fluorouracil in pregnancy. *JAMA.* 1971;217:214-215.
5. Nugent P, O'Connel TX. Breast cancer and pregnancy. *Arch Surg.* 1985;120:1221-1224.
6. Nicholson HO. Cytotoxic drugs in pregnancy: Review of reported cases. *J Obstet Gynaec Brit Cwlth.* 1968;75:307-312.
7. Sokal JE, Lessmann EM. Effects of cancer chemotherapeutic agents on the human fetus. *JAMA.* 1960;172:1765-71.
8. Sweet DL, Kinzie J. Consequences of radiotherapy and antineoplastic therapy for the fetus. *J Reprod Med.* 1976;17:241-246.
9. Stephens JD, Golbus MS, Miller TR, et al. Multiple congenital anomalies in a fetus exposed to 5-fluorouracil during the first trimester. *Am J Obstet Gynecol.* 1980;137:747-748.❑

The problem of recurrent stenosis following carotid endarterectomy

Hope S. Maki, MD; Robert A. Kruger, MD;
and Marvin E. Kuehner, MD, Marshfield

From 1977 to 1985, 306 consecutive patients underwent carotid endarterectomy by a single surgeon. The post-operative stroke and death rates were 1.3% and 2.6%. Of the 184 patients with follow-up duplex scanning, 24 (13%) had a recurrent stenosis of 50% or greater. Of 15 possible risk factors studied to assess a possible relationship with recurrent stenosis, four were definitely associated and a fifth probably implicated. The four definitely associated risk factors for recurrent stenosis were an age of 70 years or older ($p = 0.0025$), female gender ($p = 0.0001$), ulcerated lesions ($p = 0.013$), and asymptomatic lesions ($p = 0.041$). The fifth risk factor that may play a role (though not reaching statistical significance) was combined carotid endarterectomy and myocardial revascularization ($p = 0.066$). In these patients, we recommend using vein patch angioplasty to reduce the recurrence rate. *Wis Med J* 1991;90(10):583-585.

With the advent of noninvasive testing and wider use of duplex scans in the follow-up of postoperative carotid endarterectomy patients, restenosis has been found to be a more common occurrence than previously thought. Three hundred and six patients had carotid endarterectomy performed or supervised by one surgeon during the 9 years, 1977 to 1985.

Materials and methods

The 184 patients who were offered and agreed to have follow-up duplex scans (62%) form the basis of this report. Patients excluded from the

Table 1.–Fifteen variables studied to determine a possible relationship to recurrent carotid artery stenosis.

Gender
Age (less than 70 years, 70 years or older)
Preoperative symptoms (TIA[a] *v* CVA[b] *v* asymptomatic)
History of smoking
History of hypertension
History of CAD[c]
History of hypercholesterolemia (≥200 mg/dL)
History of diabetes mellitus
Presence of ulcer
Type of operation (CE[d] alone, CE plus CABG[e])
Pre-op medications (ASA[f] *v* none) (ASA *v* ASA plus dipyridamole)
Post-op medications (ASA *v* none) (ASA *v* ASA plus dipyridamole)
Recurrence in asymptomatic patients (initial disease <50%, ≥50%)

[a]TIA = transient ischemic attack
[b]CVA = cerebrovascular accident
[c]CAD = coronary artery disease
[d]CE = carotid endarterectomy
[e]CABG = coronary artery bypass grafting
[f]ASA = aspirin

study were those who had external carotid endarterectomy alone, carotid aneurysm repair, or carotid-aorta-axillo-subclavian artery bypass. Patients undergoing other simultaneous procedures (eg, myocardial revascularization and abdominal aortic aneurysm repair) were included. A statistical study was made using Chi square analysis in this group of 184 patients. Fifteen variables, as listed in Table 1, were studied.

Results

From 1977 to 1985, 306 consecutive patients underwent carotid endarterectomy by a single surgeon. The post-operative stroke and death rates were 1.3% and 2.6%. One hundred eighty-four patients (62%) had follow-up duplex scanning. Noninvasive test results were classified according to the degree of stenosis using the following scale: 0 to 15%, 16% to 49%, 50% to 80%, 81% to 99%, and occluded. Sixty-five percent (119/184) had a normal study or up to 15% restenosis. Twenty-two percent (41/184) were in the 16% to 49% range, 9% (16/184) were in the 50% to 80% range, 3% (6/184) had a high grade restenosis of 81% to 99%, and two patients (1%) had an occluded carotid artery on duplex scan. The duplex scans were all interpreted by one individual. Therefore, 13% (24 patients) had a recurrent stenosis of 50% or greater. These results compare favorably with the recent reports of Bertin, Atrip, and Healy.[1-3]

Table 2.–Four variables found to significantly increase the likelihood of recurrent carotid artery stenosis.

Age 70 years or older, $p < 0.0025$
Female gender, $p < 0.0001$
Presence of ulcer, $p < 0.013$
Asymptomatic, $p < 0.041$

We examined the 15 variables listed in Table 1 in 184 patients to determine which may be more frequently associated with recurrent stenosis. Of the 15 variables, four achieved statistical significance with $p < 0.05$. These were an age of 70 years or older ($p = 0.0025$), female gender ($p = 0.0001$), ulcerated lesions ($p = 0.013$), and asymptomatic lesions ($p = 0.041$) (Table 2). Those found not to influence recurrent stenosis were a history of smoking, hypercholesterolemia, hypertension, coronary disease, diabetes mellitus, pre- or post-operative use of antiplatelet drugs, degree of initial stenosis (less than 50% or 50% or more) in asymptomatic patients and whether or not myocardial revascularization was done in conjunction with carotid endarterectomy. It has been our impression that patients undergoing combined carotid endarterectomy and coronary vein grafting have had high rates of restenosis. The p value of 0.066, while not reaching statistical significance, is highly suggestive of biological significance. Certain potentially important technical aspects of the actual operation, that is, use of distal tacking sutures or vein patch angioplasty, could not be studied because of the number of patients in these groups was inadequate for statistical analysis.

Discussion

Recurrent carotid stenosis has only recently been recognized as a major problem. In earlier years, restudy of a post-operative carotid artery was usually prompted only by recurrent symptoms and reports from the 1970s[4,5] indicated that the symptomatic recurrence rate following carotid endarterectomy was very low (less than 2%). With the advent of reliable noninvasive testing, objective follow-up is now feasible without resorting to angiography. A recent report and review on the subject of recurrent stenosis following carotid endarterectomy by Sundt et al[6] states that recurrent stenosis of greater than 50% or occlusion occurs in 10% to 50% of patients. In a 1984 report by Glover,[7] only 42% of post-operative patients followed by duplex ultrasonographic scanning had no irregularity or stenosis at the operative site. Of our patients studied 13% had a recurrent stenosis of 50% or greater.

Other groups have associated female gender, younger age, hypertension, hypercholesterolemia, and smoking with a greater frequency of recurrent disease. Of the 15 variables we studied, four were significant predictors of restenosis. These were age of 70 years or older, female gender, ulcerated lesions, and asymptomatic lesions. To our knowledge, three of these four variables have not been reported before. At this point, with the exception of the female

Table 3.–Clinical course of the ten patients operated on for recurrent carotid artery stenosis.

Patient	Symptoms associated with restenosis	% restenosis	No. of months from initial surgery to reoperation	No. of months from reoperations to latest scan	Recurrent stenosis following reoperation
1	+	70	8	17	0
2	+	90	3	10	0
3	+	95	7	11	90
4	+	90	11	13	40
5	+	90	14	19	0
6	+	80	7	16	0
7	+	90	53	7	0
8	+	99	7	44	0
9	-	90	11	14	40
10	-	95	11	14	0

+=yes
-=no

gender, there may be no consistently accurate predictors of restenosis, since this study showed a history of smoking, hypercholesterolemia, hypertension, coronary artery disease, diabetes mellitus, pre- or post-operative use of antiplatelet agents, degree of initial stenosis in asymptomatic patients, or whether another operation was done in conjunction with carotid endarterectomy to have no statistical effect. As noted, the p value of 0.066 did not achieve statistical significance in patients undergoing combined carotid endarterectomy and myocardial revascularization. Although our institution has done 95 such combined procedures from 1971 through 1987, and of 49 being studied post-operatively with duplex scanning, 25% had a restenosis rate of 50% or more. We believe this area warrants further study.

It should also be noted that none of the patients in this study had any kind of intraoperative anatomic study. Completion duplex scanning has become the standard of care in our institution in more recent years. Residual defects, a factor not addressed in this report, may now be identified and eliminated with potentially improved long-term patency.

A total of ten patients with recurrent stenosis of at least 50% have undergone reoperative surgery, all with vein patch angioplasty. Eight were done for symptomatic disease and two were asymptomatic. Table 3 profiles these ten patients, showing the percentage of restenosis, presence of symptoms with restenosis, timing of the reoperation relative to the initial surgery, and the results of the most recent duplex scan. Of note, all patients were asymptomatic at their most recent clinic visit, although three have recurrent disease with 90%, 40% and 40% restenosis at 11, 13, and 14 months respectively. We have elected to observe these patients with no further surgery planned at this point.

In conclusion we believe that: carotid endarterectomy can be performed safely; periodic assessment of results is not only appropriate, but essential; and long-term follow-up of post-carotid endarterectomy patients should include periodic assessment with noninvasive testing and analysis of outcome to discover which patients are more prone to develop restenosis is important for the individual patient as well as a means to gain more knowledge of the nature of cerebrovascular disease in general. The ultimate goal should be to identify that subset of patients with cerebrovascular disease who may be most likely to achieve lasting benefit from carotid endarterectomy.

References

1. Bertin VJ, Plecha FR, Rogers GJ, et al. Recurrent stenosis by duplex scan following carotid endarterectomy. *Arch Surg.* 1989;124:866-869.
2. Atrip RG, Wengrovitz M, Gifford RRM, et al. A rational approach to recurrent carotid stenosis. *Journal of Vascular Surgery.* 1990;11:511-516. 3. Healy DA, Zielen RE, Nicholls SC, et al. Long-term follow-up and clinical outcome of carotid stenosis. *Journal of Vascular Surgery.* 1989;10:662-669.
4. Stoney RJ, String ST. Recurrent carotid stenosis. *Surgery.* 1976;80:705-710.
5. Hertzer NR, Martinez BD, Benjamin SP, et al. Recurrent stenosis after carotid endarterectomy. *Surg Gynecol Obstet.* 1979;149:360-364.
6. Sundt TM Jr, Houser OW, Whisnant JP, et al. Correlation of post-operative and two-year follow-up angiography with neurological function in 99 carotid endarterectomies in 86 consecutive patients. *Ann Surg.* 1986;203:90-100.
7. Glover JL, Bendick PJ, Dilley RS, et al. Restenosis following carotid endarterectomy. *Arch Surg.* 1985;120:678-684.❑

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Wisconsin's lobbying law

Sally Wencel, JD, SMS staff attorney

QUESTIONS CONTINUE to be raised regarding the 1990 revisions to Wisconsin's lobbying law and ethics code, which became effective in January 1991. Well-publicized media accounts of investigations and prosecutions of legislators and lobbyists in the past several years have increased the attention paid to this area of regulation. This article provides an overview of the lobbying regulations and restrictions. Federal law is not addressed in this article, nor is the issue of state campaign financing. General questions concerning the federal and state campaign financing requirements and prohibitions may be referred to the SMS Department of Public Affairs or Office of Legal Services.

Wisconsin's lobbying law and ethics code is found in Wisconsin Statutes §§13.61-13.75 and §§19.41-19.59 and Wisconsin Administrative Code chapters Eth 3.01 and 5.01. The law requires a lobbyist to be licensed through the state Ethics Board. It further directs organizations and persons employing or contracting with lobbyists to file periodic lobbying reports with the board, defines prohibited conduct, and sets penalties for violating the registration and reporting requirements and engaging in prohibited conduct. The state Ethics Board is empowered by statute to administer and enforce the law. The Wisconsin attorney general, at the request of the board, may commence civil actions to require payment of forfeitures for violations determined by the board. The attorney general, as well as the local district attorney may, upon any information, seek criminal conviction for violations for which the law provides criminal penalties.

Organizations, including medical societies and their auxiliaries, clinics, and persons affiliated with them, need to determine first whether they are engaged in lobbying as defined by this law and, if so, whether they are properly complying with the law concerning reporting and registration. Under most circumstances, these organizations and persons do not qualify as either lobbyists or principals for whom the lobbyists work and need not be concerned about violating the state lobbying laws and regulations.

Who is covered?

A lobbyist is defined as a person who is employed by a principal, or contracts for or receives economic consideration, other than reimbursement for actual expenses, from a principal and whose duties include lobbying on behalf of the principal. A principal is any person or organization who employs or contracts with a lobbyist. If a membership association engages a lobbyist, the members of the organization are not considered principals. In the same way, the shareholders, partners, officers, and other employees of an association, corporation or partnership are not covered by the provisions applying to principals.

There are two elements to the definition of a lobbyist–the person must engage in lobbying activities and receive compensation ("economic consideration") for these activities beyond payment or reimbursement for actual expenses. The payment must be made by the principal specifically for performing the lobbying activity.

Volunteers participating in activities such as speaking before legislative committees and contacting state legislators and other state officials, activities that otherwise might be considered lobbying, are not considered lobbyists because they are not paid for these services. Thus, members of an association such as the SMS are not considered "lobbyists" when contacting state officials on behalf of the SMS or as representatives of the SMS.

Contacts with your legislator are completely exempt from the regulation of lobbying. This issue is dis-

Continued on next page

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cussed in greater detail below.

Persons who do not fit the definition of lobbyist need not comply with the licensing requirements and the organizations on whose behalf the lobbying is performed and which otherwise do not employ lobbyists need not comply with the registration and filing requirements described later. These organizations are, however, subject to campaign finance restrictions and must limit activities which are covered by state and federal campaign finance and elections laws.

What is lobbying?

Lobbying is defined as attempting to influence legislation or administrative rules by communicating with state officials, legislative employees, and agency officials. Communication means any oral or written communication with any agency official, elective state official or legislative employee that attempt to influence legislative or administrative action. If a person's duties to the principal are not limited to lobbying, the person is considered a lobbyist only if he or she makes lobbying communications on each of at least 5 days during a 6-month reporting period. This reporting period also defines the time for expense statement filings as discussed later. The reporting period is defined as the 6-month period beginning Jan 1 and ending June 30 or beginning July 1 and ending Dec 31 of any year.

Certain activities are specifically exempted from coverage. These exemptions include:

- lobbying through communications mediator by publicly addressing audiences primarily made up of persons other than legislators or agency officials;
- news or feature reporting, paid advertising or editorial comment by working members of the press, publications or dissemination by newspaper, book, regularly published periodical, radio or television station; or
- participating as a member of a legislative or agency advisory committee.

The lobbying law does not interfere with a person's right to communicate with state or agency officials solely on his or her behalf. The law also specifically exempts from lobbying regulation a person's right to communicate with the legislator representing the district in which he or she resides, regardless of whether the communication is on the person's or another's behalf. Therefore, you may ignore reporting and registration requirements if you limit your lobbying to legislators elected from the district in which you reside. In addition, even if you contact legislators other than your own, if you are lobbying on behalf of the SMS you are not required to register as a lobbyist unless you are compensated by the SMS (reimbursement for actual and necessary expenses is not defined as "compensation").

Licensing and registration

Lobbyist. Every lobbyist must file for and obtain a license from the state Ethics Board. The license entitles the licensee to lobby on behalf of the principals which have filed an authorization for him or her. The license is valid through the last day of the next even-numbered year.

Principal. Principals must file lobbyist authorizations, lobbying registration statements and lobbying expense statements with the state Ethics Board. The lobbyist authorization is a written statement signed by or on behalf of the principal that it has engaged a lobbyist to represent the principal. A separate authorization must be submitted for each lobbyist retained or employed

When is a license to lobby required?

- You have an obligation to obtain a lobbying license from the Ethics Board if you attempt to influence state legislation or administrative rules on behalf of a business or organization by which you are employed, or from which you receive payments other than reimbursement costs you incur on its behalf, and you communicate with state officials or legislative employees about those matters on 5 or more days within a 6-month period.
- If you are not acting on behalf of anyone other than yourself, you need *not* be licensed.
- Even if you represent the views of a business or organization but do so as an unpaid volunteer, you need *not* be licensed.
- Even if you represent the views of a business or organization that pays you, but convey those views only to legislators elected from the Senate and Assembly districts in which you reside, you need *not* be licensed.
- Even if you represent the views of a business or organization that pays you and convey those views to all or many legislators or officials but do so only occasionally, up to 4 days within a 6-month period, you need *not* be licensed.

Otherwise, you should be licensed as a lobbyist and your employer should be registered with the Ethics Board. Applications are available from the Wisconsin Ethics Board.

This is a guide. For authoritative information consult the Wisconsin Statutes.

by the principal. Registrations also expire on the last day of each even-numbered year.

Reporting requirements

Lobbyists and principals must keep detailed records of the time spent on lobbying and the expenses associated with their lobbying, and must file reports with the state Ethics Board every 6 months. The reports must be filed and records kept on forms prescribed by the Ethics Board.

Lobbyists are required to maintain a contemporaneous record of the time they spend on lobbying each day by subject and of the time they spend on research or preparation for lobbying (also by subject) and related activities. In addition to reporting lobbyists' time and the cost of lobbying personnel, each principal must report all organizational costs associated with lobbying, including the costs of administrative support and research. The organization must also now track and report the time spent by its members on lobbying-related activities (for example, the total time spent by a committee in discussions of legislative strategy).

Prohibited conduct

The general rule is that no principal or lobbyist may furnish anything of value to any elected official, legislative employee, agency official, or candidate for an elective state office (from here on referred to as "restricted person") nor may the restricted person accept such items. The law also regulates the proper manner by which lobbyists and non-corporate principals may make campaign contributions. (Domestic and foreign corporations, and cooperatives are not allowed to make any political contributions under the campaign financing laws of Chapter 11, Stats.)

This prohibition does not bar state officials and other restricted persons from attending receptions or other functions sponsored by organizations that register as principals as described above. The officials, however, must pay the actual cost of the food or beverages they consume.

The law does allow legislators and other state officials to accept coverage of expenses or reimbursement of expenses, as well as honoraria, in certain situations. An organization may offer, and a state official may accept, transportation, lodging, and food and beverages if the state official is speaking at a meeting. A state official may also accept fees or honoraria for making a presentation, so long as the fees or honoraria are not paid by a principal or lobbyist. In addition, a state official may accept transportation, lodging, and food and beverage if those items are offered to the general public (and not offered by a principal or lobbyist).

The law also prohibits a lobbyist from instigating

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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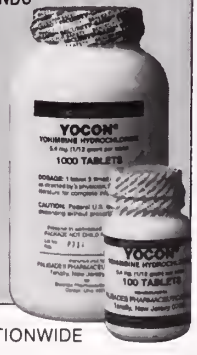

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legislation or administrative action for the purpose of obtaining employment. A lobbyist may not be paid on a basis contingent on the success or failure of any legislative or administrative action.

Enforcement and penalties

The state Ethics Board is empowered to investigate alleged violations of the lobbying laws. These investigations may be initiated upon the board's acceptance of a written, verified complaint from any person, organization or governmental body. As mentioned earlier in this article, the board may, depending upon the nature of the facts alleged, refer a case to the Attorney General or district attorney for civil or criminal action.

The state Ethics Board is directed to provide advisory opinions to persons with questions concerning the lobbying laws. A person obtaining an opinion from the Board may rely on it as evidence of his or her intent to comply with the law to the extent the relevant facts stated in the opinion are the same. Asking questions is advisable–the penalties for violating the lobbying provisions can be steep. Lobbyists and principals may be fined up to $10,000 or imprisoned up to five years or both for certain offenses. Neither the Ethics Board or its employees may release the identity of individuals or organizations requesting an opinion. Questions may be directed to: State Ethics Board, 44 E Mifflin St, Suite 601, Madison, WI 53703; (608) 266-8123.❑

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Public health

Identifying women who have never had a mammogram

Paula M. Lantz, MA; Patrick L. Remington, MD; and Eleanor Cautley, MS, Madison

THE USE OF MAMMOGRAPHY screening for the early detection of breast cancer has been increasing nationally and in Wisconsin as well. We previously reported an 18-fold increase in the annual number of mammograms performed in Wisconsin between 1980 and 1989.[1] Despite this encouraging trend, however, a substantial number of women age 40 and older have never had a mammogram.

In an attempt to identify demographic characteristics of women who have never had a mammogram, we analyzed data from the 1987 to 1990 Wisconsin Behavioral Risk Factor Surveys (BRFS). The BRFS are annual random-digit dial telephone surveys of the health practices of Wisconsin adults. The purpose of the analysis is to identify subgroups of women who are at higher risk for never having a mammogram and who could benefit from targeted interventions for increased screening.

The analysis was limited to women ages 40 and older (N=1,416). The data were weighted in the analysis to adjust for the age-sex distribution in the population. Contingency tables were constructed to identify associations between six socioeconomic variables and never having a mammogram. In addition, we used multiple logistic regression techniques to measure the strength of the relationship between each socioeconomic variable and never having a mammogram while controlling for the other factors.

Results

Among women 40 and older, 37% had never had a mammogram. This percent has been decreasing over time, as shown in Table 1. This table also displays the percent of women who have never had a mammogram by the various socioeconomic factors under study. Women ages 40 to 49 and 65 and older are less likely to have ever had a mammogram than women ages 50 to 64 years. In addition, women who have less education, have a lower income, reside in a rural county, or have not seen a physician in the past year are significantly less likely to have ever had a mammogram. When some of these factors are combined, even greater

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Table 1.–Percent of Wisconsin women age 40 and older who have never had a mammogram by demographic factors, 1987-1990.

Factor	Percent
Year*	
1987	45%
1988	39%
1989	33%
1990	34%
Age*	
40-49	40%
50-64	33%
65+	39%
Education*	
less than high school	43%
high school graduate	41%
some college or vocational school	32%
college graduate	28%
Annual household income*	
<$15,000	44%
$15,000 to $35,000	37%
>$35,000	27%
County of residence*	
metropolitan	33%
non-metropolitan (rural)	39%
Race	
white	37%
minority	39%
Last routine check-up*	
within the past year	29%
more than a year ago	58%
Total sample (N=1,416)	37%

*Differences statistically significant, p<.01

Lantz is a senior research specialist in the Center for Health Policy and Program Evaluation and a PhD candidate at the University of Wisconsin-Madison. Dr Remington is a medical epidemiologist in the Chronic Disease Surveillance Unit, Section of Environmental and Chronic Disease Epidemiology, Wisconsin Division of Health. Cautley is a research analyst in the Center for Health Statistics, Wisconsin Division of Health, and the coordinator for the Wisconsin Behavioral Risk Factor Surveys. Part of this work was made possible by a grant from the National Cancer Institute (#R01-CA-46883). Reprint requests to: Patrick L. Remington, MD, Wisconsin Division of Health, 1 W Wilson St, Madison, WI 53701-0309. Copyright 1991 by the State Medical Society of Wisconsin.

Continued from preceding page
differences in the use of mammography can be described (Table 2). For example among those who have low education, low income, and have not had a recent routine contact with a physician, 62% have never had a mammogram.

The results of the multivariate analysis (not presented here) indicate that when these demographic factors are considered simultaneously, the only factor that is significantly related to never having a mammogram is a recent routine check-up. This (and further evidence from model-testing analyses) suggests that the mechanism by which age, education, income, and county of residence are related to mammography use is through their more direct association with a recent physician contact.

Comment

Despite the controversy regarding the appropriate age to begin screening and the optimal time interval between procedures, it is generally agreed that all women 50 and older should have had at least one screening mammogram.[2] Because women who have never had a mammogram are at the greatest risk for having breast cancer diagnosed at a late stage, intensive efforts to identify and screen these women should be made.

Approximately one out of four women in the sample (27%) reported that they had not seen a physician for a routine check-up within the past year. The majority of these women (58%) have never had a mammogram.

Table 2.–Percent of women in selected demographic groups who have never had a mammogram, Wisconsin, 1987-1990.

Demographic group	% Never had a mammogram
● more than a high school education, annual income greater than $35,000, and routine check-up within the past year	20%
● more than a high school education, annual income greater than $35,00, and no routine check-up within the past year	32%
● high school graduate or less education, annual income less than $15,000, and routine check-up within the past year	40%
● high school graduate or less education, annual income less than $15,000, and no routine check-up within the past year	62%

These results suggest that women who have not had a recent routine contact with the health care system are at a high risk for never having a mammogram. These women represent an important target group for outreach from health clinics, local public health agencies and voluntary groups such as the American Cancer Society.

Approximately three out of four women in the sample (73%) reported that they had seen a physician for a routine check-up within the past year. A significant number of these women (29%), however, also reported that they have never had a mammogram. These women actually represent the majority of the women under study without a prior mammogram (321/533 or 60%), and are an important and identifiable target group for physicians. Prior research has shown that one of the most common reasons women give for never having a mammogram is that a physician has never recommended the procedure.[3,4] The National Cancer Institute recommends that physicians use the clinical breast examination as an opportunity to discuss screening mammography with appropriate female patients.[5]

The BRFS data show an increase in the number of Wisconsin women who report having a prior mammogram between 1987 and 1989. The trend data, however, also suggest a plateau in this advancement. Based on the most recent survey results, we estimate that approximately 338,000 Wisconsin women age 40 and older have never had a mammogram, although approximately 196,000 (58%) of these women have had a recent medical check-up. Substantial progress in mammography use could be made if every women who saw a physician was offered–and accepted–a routine screening mammogram.

Acknowledgement

The authors wish to thank Gianfranco Pezzino, MD, Mary Manering, RN, and Robert Anda, MD, for their helpful comments.

References

1. Lantz PM, Bunge M, Remington PL. Trends in mammography in Wisconsin. *Wis Med J* 1990;89(5):82-83.
2. US preventive services task force. Guide to clinical preventive services. Baltimore: Williams & Wilkens, 1989.
3. Rimer BK, Keintz MD, Kessler HB, et al. Why women resist screening mammography: Patient related barriers. *Radiology* 1989;172:243-246.
4. Lantz PM, Remington PL, Soref M. Self-reported barriers to mammography: Implications for physicians. *Wis Med J* 1990;89(10):602-606.
5. National cancer institute breast cancer screening consortium. Screening mammography: A missed clinical opportunity? *JAMA* 1990;264(1):54-58.❑

A report on budget vetoes affecting health care issues

When Gov Tommy Thompson signed AB 91, Wisconsin's 1991-1993 biennial budget proposal, he vetoed–among his record 457 partial vetoes–the many large appropriations for the second year of the biennium, (July 1, 1992, through June 30, 1993). As a result, the Legislature will have to enact another major budget bill in early 1992. The Legislature must also deal with reapportionment before its 1992 adjournment, and has expressed plans to address the issues of abortion and health care system overhaul this fall or next spring.

Highlights of vetoes affecting various health-related issues include:

Medicaid reimbursement

Gov Thompson vetoed the entire second-year appropriation for payment of all Medicaid benefits, including physicians' services. As a result, only those increases incorporated in the first-year appropriation are certain; all others will have to be reconsidered in the 1992 budget adjustment bill. Many of the improvements in physician reimbursement were scheduled to begin in the second year, including:

- a 2% across-the-board increase ($1.4 million all funds);
- increased payment for obstetric services to 70% of average charges effective July 1, 1992, ($2.9 million), and to 75% Jan 1, 1993, ($814,000);
- increased payment for pediatric services to 70% of average charges effective Jan 1, 1993, ($433,000); and
- payment for physician office visits at 65% of average charges (or more in the case of obstetric or pediatric services, as above), effective July 1, 1992, ($2.2 million).

Increases for physicians' services remaining in the first year are a 1% across-the-board increase ($700,000); increased payment for pediatric services to 65% of average charges effective Jan 1, 1992, ($5.7 million); a 10% "bonus" payment for primary care services provided in, or to residents of, health professional shortage areas ($454,000). Details for implementation of this last provision have yet to be worked out.

While the SMS is disappointed with the veto of the second-year Medicaid

Continued on next page

Wisconsin physicians respond to HCFA in record numbers

In recent weeks, physicians from around Wisconsin have responded to the SMS's "Call to Action" regarding the Health Care Financing Administration's (HCFA) proposal for implementation of the Resource-Based Relative Value Scale (RBRVS). The SMS has received copies of letters from hundreds of physicians commenting on the draft regulations for RBRVS and expressing concern and anger over HCFA's proposal to implement a 16% reduction in the conversion factor. The SMS extends its appreciation to those physicians who wrote and encourages those who have not yet done so to contact their Wisconsin representatives and senators.

According to the AMA, HCFA received more than 44,000 comments regarding the proposed rules prior to the Aug. 5, 1991, deadline. The AMA expects that number to increase significantly as the bulk of comments on regulations are not typically received until the day of the deadline.

"In our discussions with the AMA, it has become apparent that HCFA is feeling overwhelming pressure to rescind its proposed conversion factor," said SMS Secretary-General Manager Thomas L. Adams, CAE. "But because the new levels have not been set, continued pressure is needed to restore the conversion factor to its proper level."

In addition to providing comments to HCFA, Wisconsin physicians and physicians from across the nation have met with, written, or called their representatives and senators in overwhelming numbers. By mid-August, 72% of Congress had written HCFA or the Department of Health and Human Services demanding changes in the proposed rule. All Wisconsin representatives and senators have expressed their opposition to HCFA's proposal.

While Congressional leaders continue to press for an administrative rather than legislative solution, Ways and Means Health Subcommittee chair Pete Stark (d-Calif) has introduced legislation to correct the conversion factor problem if the Bush administration decides to proceed with the 16% cut. Rep Stark also noted, however, that legislation should be the response of last resort. With final rules from HCFA expected in October, Capitol observers expect a signal from the administration in September as to whether the 16% cut will be withdrawn.❑

Continued from preceding page
appropriation, it will work with the Legislature and the governor's office to try to ensure that these important improvements in access to physicians' services for Medicaid patients are preserved in the 1992 budget adjustment bill.

Medicaid HMO initiative
Gov Thompson vetoed a request for a Legislative Audit Bureau study of this initiative, including an examination of physician payment rates, indicating that the Legislature could request this study without statutory language.

Emergency medical services
Language creating an EMS Council and a Medical Care Council advising the EMS Council was vetoed. The governor cited the 1989-1990 legislation creating the EMS Assistance Board, which can perform duties similar to those proposed for the council.

Cigarette tax increase
As previously announced, the governor vetoed the 10 cent cigarette tax increase, which would have made Wisconsin's tax at 40 cents a pack the fourth highest in the nation. He also announced, however, that he would seek a 5 cent increase in a revenue adjustment bill this fall.

Medical waste management
At the request of the SMS and others, Gov Thompson vetoed provisions which would have established statutory percentage requirements for each hospital's reduction of medical waste, a requirement which many hospitals indicated would affect their willingness to dispose of physicians' and clinics' medical waste. The governor also vetoed provisions setting new requirements for the location and operation of medical waste incinerators. Left intact, however, is a provision requiring Department of Natural Resources licensure of every person who transports medical waste (presumably including transport from a physician's office to a hospital). The SMS had requested a veto of this provision.❑

AMA awards

The Wisconsin physicians listed below recently earned AMA Physicians Recognition Aards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates a member of the SMS.

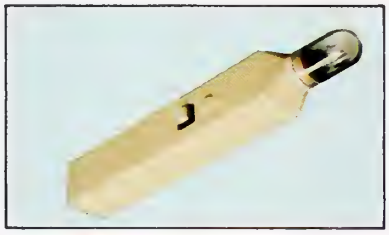
June 1991
* Ahmad, Muhammad Y., of Merrill
* Anderson, Earl L., of Waupaca
* Beatty, Peter A., of Madison
* Bloomberg, Paul, of Ellsworth
* Brandstetter, Yuval, of Milwaukee
* Champaloux, Alain G., of Chippewa Falls
* Erickson, Rodney A., of Tomah
Feenstra, David S., of Madison
* Gahl, Robert A., of Two Rivers
Gaaaolz, Robert K., of Appleton
Hahn, Michael F., of Janesville
* Kim, Byung Hoon, of Racine
Kolesari, Gary L., of Milwaukee
* Lauderdale, Barbara L., of Neenah
* Lindsey, Everett R., of Mineral Point
* Listwan, William J., of West Bend
* Matzke, Robert F., of Janesville
* Matzke, Rudolf W., of Spooner
* Mayer, Vicki L., of Hudson
* Quackenbush, Steven R., of Wisconsin Rapids
Sneed, Robert J., of Ashland
* Tanel, Gwendolyn A., of Waukesha
* Wadhwani, Indur B., of Racine
* Zach, Robert G., of Crandon❑

Crownhart memorial supports *WMJ*

EACH YEAR, the interest from the Crownhart Memorial Fund is donated by the SMS Charitable, Educational and Scientific Foundation and the Crownhart family to the *Wisconsin Medical Journal* as publication support for the special July organizational issue. This year, the fund donated $474. The Editorial Board and staff of the *WMJ* offers their thanks.❑

That was then . . .

this is the future!



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Marilyn Marquardt
Head Nurse, Riverview Family Birthplace (LDRP)
Riverview Hospital, Wisconsin Rapids

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Rules on wearing special equipment in high school athletics

THERE ARE A NUMBER of provisions in the National rule books for the various sports which pertain to the wearing of special equipment and braces. The following is provided as a summary for easy reference for physicians providing physicals to student athletes and those serving as team physicians. These rules apply for 1991-1992 only.

Baseball
Rule 1, section 1:

Article 5. A pitcher shall not wear any item on his hands, wrists, or arms which may be distracting to the batter.

Article 6. All casts, splints, and braces must be padded. No protective equipment shall have exposed metal or any other hard material. Prostheses may be worn.

Note: Any equipment judged by the umpire to be potentially dangerous is illegal. Jewelry is prohibited. Medical alert bracelets or medical alert necklaces are not considered jewelry. If worn, they must be taped to the body so as to remain visible.

Basketball
Rule 3, section 5: The referee shall not permit any player to wear equipment which, in his or her judgment, is dangerous or confusing to other players or is inappropriate. This includes, but is not limited, items such as:

Article 1. A guard, cast, or brace made of hard and unyielding leather, plaster, pliable plastic, metal or any other hard surface–even though covered with soft padding–when worn on the elbow, hand, finger, wrist or forearm;

Note: Each state association may authorize the use of artificial limbs which in its opinion are no more dangerous to players than the corresponding human limb and do not place an opponent at a disadvantage.

Football
Rule 1, section 5:

Article 3. Types of equipment or substances which shall always be declared illegal include:

- projecting metal or other hard substance on clothes or person;
- any substance such as leather, rubber plastic, or fiberglass which is hard in its final form and worn on the elbow, hand, wrist or forearm even though covered with soft padding;
- knee braces made of unyielding material, unless hinges are covered on both sides and all of its edges overlapped and worn under the pants (Unless covering is provided by the manufacturer, any portion of the brace made of hard material and extending below the pants must be covered. Any other hard substance across the front of the leg must be covered with at least 1/2-inch of closed-cell slow recovery rubber or other material of the same minimum thickness and having similar physical properties.);
- forearm pads, hand pads or gloves, unless sanctioned by the umpire as being made entirely of soft nonabrasive, non-hardening material which poses no danger to the wearer or other players (Athletic tape may be used at each end to anchor such pads.);
- tape, bandage, or support wrap on the hand or forearm, unless sanctioned by the umpire as being non-hardening, nonabrasive tape, bandage, or support wrap, not to exceed three thicknesses, and sweatbands, when any of these are worn on the wrist beginning at the base of the thumb (proximal end of the metacarpal bone) and extending not more than 3 inches toward the elbow, are legal without inspection or sanction.

Gymnastics
Rule 3, section 3:

Article 3. Jewelry shall not be worn in competition except for a religious or medical medal which must be taped to the body.

Article 5. Casts on any body parts are prohibited.

Point of Emphasis. Air type "casts," cast-braces, and knee braces are legal provided all hard parts are covered to protect the gymnast and the equipment.

Hockey
Rule 3, section 5:

Casts and splints made of hard or unyielding material are illegal, even if padded.

Soccer
Rule 4, sections 1 and 2:

Article 1. Illegal equipment shall not be worn by any player. This applies to any equipment which, in the opinion of the referee is dangerous or confusing. Types of equipment which are always illegal include the following:

- projecting metal or other hard plates, or projections on clothing or person;
- head, arm, thigh or hip pads containing sole leather, fiber, metal or any unyielding materials, even if they are covered with soft padding;

Continued on next page

Continued from preceding page

- hard casts or hard splints of any material, even if padded;
- shin guards which have exposed sharp edges;
- face or spectacle guards;
- helmets, hats, caps, or visors;
  (Exception 1. The goalkeeper may wear a head protector made of closed-cell, slow-recovery rubber or other similar material that stays soft in its final form. This head protector shall not have a bill or other protruding design. It shall not cover the face, other than the forehead, and shall be secured by a shin strap.
  Exception 2. The goalkeeper may wear a soft-billed baseball type hat or soft-billed visor. If worn in conjunction with a head protector, it is to be worn outside and may not be attached to the head protector.
  Exception 3. By state association adoption, players may wear soft and yielding caps during inclement weather. Caps must be alike in color.)
- Knee braces made of hard unyielding material, unless hinges are covered on all sides, and all of its edges are overlapped; any other hard substance shall be covered with at least 1/2 inch (0.0127m) of closed-cell slow-recovery rubber or other material of the same minimum thickness and having similar physical properties;
- ankle braces, unless covered by a stocking or other suitable material.

Note: The wearing of illegal uniforms or equipment is prohibited even though the coaches of both teams approve it.

Article 3. Players shall not wear jewelry with the exception of medical medals which shall be taped inside the uniform if worn.

Article 5. Artificial limbs, which in the judgment of the State High School Association are no more dangerous to players than the corresponding human limb and do not place an opponent at a disadvantage, may be permitted. Upper limb prostheses are discouraged. Hinges shall be lateral and covered by leather. All permissible artificial limbs shall be covered by at least 1/2 inch (0.127m) foam rubber padding.

4-2-6-hearing aids worn in or behind the ears are legal provided that the device does not create the threat of injury.

Softball

Rule 1 section 1:

Article 9. Jewelry is prohibited. Medical alert bracelets or necklaces are not considered jewelry. If worn, they must be taped to the body, so as to remain visible. All casts, splints, and braces must be padded. Any equipment judged by the umpire to be potentially dangerous is illegal.

Swimming and diving

Rule 3, section 3:

Article 3. A handicapped competitor with a missing limb may use a hand paddle or artificial limb provided in the judgment of the state association, it is no larger than the corresponding natural limb and no advantage is gained. The written approval from the state association must be made available to the referee.

Track and field and cross country

No specific rules other than the prohibition of any equipment or device that might enhance performance.

Volleyball

Rule 4, section 1:

Article 1. A guard, cast or brace made of hard and unyielding leather, plaster, pliable plastic, metal or any other hard substance, even though padded, is not permitted on the finger, hand, wrist, forearm or elbow.

Article 2. Supports are permitted on other parts of the body as long as they are soft and yielding or covered. All metal frames shall be padded.

Article 3. Artificial limbs are permitted when, in the judgment of the state association, they are no more dangerous than the corresponding human limb, or adequately padded.

Article 4. Any equipment that increases a player's advantage is prohibited.

Wrestling

Rule 4, section 3:

Article 1. Any mechanical device which does not permit normal movement of the joints and which prevents one's opponent from applying normal holds shall not be permitted. Any equipment which is hard and/or abrasive must be covered and padded. All special equipment must be unadorned.

Article 2. Artificial limbs, which, in the judgment of the rules administering officials (state association office), are no more dangerous to contestants than the corresponding human limb and do not place an opponent at a disadvantage, may be permitted.

Article 3. Loose pads are prohibited.

Article 4. Taping or strapping which substantially restricts the normal movement of a joint shall be prohibited.

For more information, contact the WIAA, PO Box 267, Stevens Point, WI 54481-0267.❑

The children are our future

Marlene A. Scott, assistant editor

CHILDREN ARE the least well-served population in the United States, not only health-wise but socially," said Daniel W. Shea, MD, the American Academy of Pediatrics' (AAP) newly elected president. "Children don't vote and have no clout. Someone has to speak for them."

Dr Shea became president elect of the AAP in October 1990. He assumes the presidency this month and will lead the 41,000 member AAP for the next year. A medical graduate of St Louis University, Dr Shea has practiced pediatrics for more than 33 years in Green Bay.

"Children are the most vulnerable part of our society and they are our future," said Shea. "It is time for us to become a nation that makes children's health a top priority.

"Children are unable to choose their parents (ie, parents free from AIDS, crack and other drug addictions, and those without insurance). The academy has to speak for them."

For more than 60 years, the AAP has positioned itself as a leading voice for children, and established principles which guide the academy today. Shea said the academy has fought tirelessly to develop and protect programs for children, and to ensure that children's needs are met at every level.

Most recently, the academy has worked with a number of Hollywood figures to promote immunization awareness in the nation during National Immunization Week, Sept 23-29, 1991. The Children's Action Network, a nationwide effort, was developed to increase awareness of the need to be immunized.

"The immunization status in the United States is a national disgrace," Shea said. "The percentage of fully immunized 2-year-olds is decreasing and one child under 5 years old dies every week of measles–a completely preventable disease." According to Shea, most of those cases occur in the rural and inner-city areas and that they are increasing. Only 50% to 70% of 2-year olds are immunized for measles in these areas.

In addition to the immunization project, Dr Shea plans to focus on the issues of quality of care and the state of the uninsured.

"My interests over the last few years has been in the area of quality care. The AAP Council on Pediatric Practice has been looking at practice parameters, and I'd like to see this initiative move ahead to enhance more quality care."

Shea is also concerned about the state of the uninsured in the United States. "Lack of health insurance is the most significant barrier to access to health care in our country. Children are affected by it (uninsurance) before they are even born."

Shea said that the increasing awareness of the problems of the uninsured and the increasing costs of health care has created a strong motivation for reforms in the American health care system. To address that need, the academy has set for itself six strategic goals, the first of which addresses the issue of increased access to care.

Daniel W. Shea, MD

Shea said that the leadership of the academy, the executive committee, the staff, and the state chapters should all focus on these six issues. "Without forsaking any of the ongoing things we've been focusing on for more than 60 years, we'll use these six issues to guide us for the coming years."

According to Shea, the academy

Continued on page 601

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Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – *Pregnancy Category C* – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
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References

1. Data on file, Lilly Research Laboratories
2. *Scand J Gastroenterol* 1987,22(suppl 136):61-70
3. *Scand J Gastroenterol* 1987,22(suppl 136):47-55
4. *Am J Gastroenterol* 1989,84:769-774

NZ-2943-B-149347

Additional information available to the profession on request.

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Continued from page 599

has limited funding and resources and the strategic plan gives the AAP some guidelines on how to set priorities.

In the movement toward universal access to care, the academy has created the Children First plan.

"The academy has designed a plan for all Americans and reflects what the membership sees as pressing needs," Shea said. "Children First intends to be a universal system, starting with children and pregnant women first." The plan will embrace the single-tier system and will not be affected by ability to pay or rationing. Shea said it will also provide freedom of choice and the preservation of pluralistic public and private insurance, with the exception of Medicaid.

The plan, to be introduced to Congress, builds on the current free enterprise system of health insurance and the shared financial responsibilities of the public and private sectors. It will provide prenatal, preventive, acute, chronic and rehabilitative services to all children and pregnant women regardless of level or source of income.

Children First

All children through age 21 and all pregnant women, will be guaranteed financial access to necessary, appropriate and effective health care services, regardless of family income, employment status, ethnic origin, geographic location or health status.

A single-class system of medical care will be established by replacing, with private insurance, the portion of the Medicaid program currently serving children and pregnant women, and by requiring uniform benefits.

Both the private and public sectors of society will have a shared responsibility for funding the system.

Patient will choose their insurance plans and physicians; similarly, physicians will choose acceptable plans and caseloads.

Administrative procedures will make this system "user friendly."

Compensation for services will be set by the marketplace, not the federal government.

Costs will be contained through increased use of preventive services, use of case managers and cost sharing.

In other matters, the academy does not support mandatory AIDS screening for health care workers. "The academy supports the Centers for Disease Control guidelines and recommendations," said Shea. "There are many good reasons for that."

Shea pointed out that even if a patient learns that a health care worker tested negative for HIV today, it cannot be assumed that the health care worker is not infected. "There is a 6-month lag period, so you get a false sense of security."

Health care workers need to address each invasive procedure as if the patient were HIV-positive, Shea said. "There has never been a documented case of HIV infection being passed from a physician to a patient," said Shea. "We know of a dentist in Florida, but we do not know of a physician. Health care workers are far more at risk (of being infected) than patients are."

Through his 33 years of practicing medicine, Shea has seen the health status of adolescents diminish. The reasons, said Shea, include increased poverty, increased drop-out rates and decreased employability. "The increase in single-teen pregnancies, sexually transmitted diseases, and injuries by violence are astounding," Shea said. "The teens of today are not healthy."

Shea has strong views on the medical profession. "I don't subscribe to the notion that medicine has become more of a business than a profession. To me it has always been a profession.

"I do, however, see a need for a physician and a practice to survive to depend on better administrative skills to deal with the harsh realities of life

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right now. I'm talking about third-party payors, Medicaid, Medicare, and PROs–the whole gamut of institutions that have injected themselves into the physician-patient relationship."

Shea said that physicians have had to become more skilled in the non-medical aspects of practice to make the medical aspects work.

In his long and successful career, Shea has seen many changes in the way medicine is practiced, the way it is regulated, and its focus. The bottom line, for him, is the well-being of the patient and the lasting relationships formed.

"I've had many gratifying experiences in my career," Shea said. "But I think one of the best is when a patient of mine grows up and comes back with their children. I don't think there's a greater compliment."❑

New PartnerCare cards

THE DEPARTMENT of Revenue (DOR) began mailing the 1991-1992 PartnerCare cards to eligible senior citizens in early October. The new cards are yellow and will replace the blue PartnerCare cards mailed last year. Patients may present either the blue or yellow cards to physicians' offices for the remainder of 1991.

PartnerCare is the voluntary Medicare assignment program sponsored by the SMS and the Coalition of Wisconsin Aging Groups. Physicians who participate in the program agree to accept assignment for all services covered by Medicare rendered to PartnerCare patients. Patients remain responsible for the 20% co-payment, $100 deductible, and non-covered services.

The DOR mailed approximately 133,000 PartnerCare cards to Wisconsin residents last year, and expects to distribute a similar number of cards this year. The SMS thanks all those physicians who have made this program a success. If your patients have questions about the program that you are unable to answer, refer them your local office on aging.❑

Employer health care coalitions

IN RECENT MONTHS, many SMS members have raised questions concerning the various employer health care coalitions or active group purchasing initiatives operating around Wisconsin. Such groups are operating in Milwaukee, in Racine, and in the Manitowoc-Two Rivers area, and other areas. The SMS is monitoring the practices of these entities and is interested in hearing from members regarding their experiences and concerns.

These coalitions or initiatives are organizations of employers, each of which maintains a separate health benefits plan. These entities often develop a fee schedule for medical services and may attempt to sign up a panel of participating physicians willing to accept payment under the fee schedule as payment in full. Non-participating physicians, too, are generally reimbursed at the fee schedule amount, but may bill patients for the difference between the fee schedule amount and their usual charges. Although the physician receives payment from the particular employer plan that is responsible for the patient, each employer generally agrees to make payment according to the fee schedule developed by the entity.

It is imperative that a physician be provided with accurate information during the negotiation of their participation agreement. If a physician is subjected to unfair pressure to sign an agreement or their patients are being provided with erroneous information, such practices may constitute a possible violation of federal or state laws concerning anti-trust or unfair trade practices.

The SMS would like to know of your concerns and experiences with employer health coalitions or group

Continued on page 604

Charity Golf Classic Sponsors

The SMS Charitable, Educational and Scientific Foundation would like to acknowledge the following companies and individuals who contributed to the second annual Charity Golf Classic. The success of the event can be attributed to the dedication, energy, and financial commitment of these sponsor participants:

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Continued from page 602
purchasing initiatives, and is particularly interested in gathering information regarding: the number of employers who are participating in the coalition or group purchasing initiative, the number of lives covered by the entity, or other matters pertinent to the participation decision; tactics used to convince physicians to become participating physicians; "patient education" campaigns that refer to charges beyond the entity's fee schedule amount as "overcharges," "excessive charges," or the like; entities that include 30% or more of the local health care purchasing market; and efforts by entities to discourage the formation of competing purchaser organizations. The SMS is also interested in hearing from physicians who have had favorable experiences with employer health care coalitions or group purchasing initiatives.

Physicians with relevant information to report should contact Sally Wencel or Mark Adams of the SMS Office of Legal Services at 1-800-362-9080 or (608) 257-6781.❑

SMS questions state Medicaid report

THE FEDERAL GOVERNMENT has agreed with the SMS that the Wisconsin Bureau of Health Care Financing has overstated the number of obstetricians serving Medicaid recipients and, in doing so, is exaggerating access to such services for the poor.

While the bureau says there are 411 obstetricians serving Medicaid patients, the SMS and the Office of Health Care Information contend there are only 360 obstetricians delivering babies in the entire state. That discrepancy, in part, lead the federal Health Care Financing Administration to reject outright the state assurance report that claimed to document that Medicaid patients here have adequate access to obstetricians and pediatricians.

The SMS, in a letter asking HCFA to reject the state report, said the numbers submitted by the report "are so seriously flawed that their use to assess access and full participation must be viewed with extreme skepticism." The state is preparing a new report for submission this month, which state officials hope will satisfy federal objections.

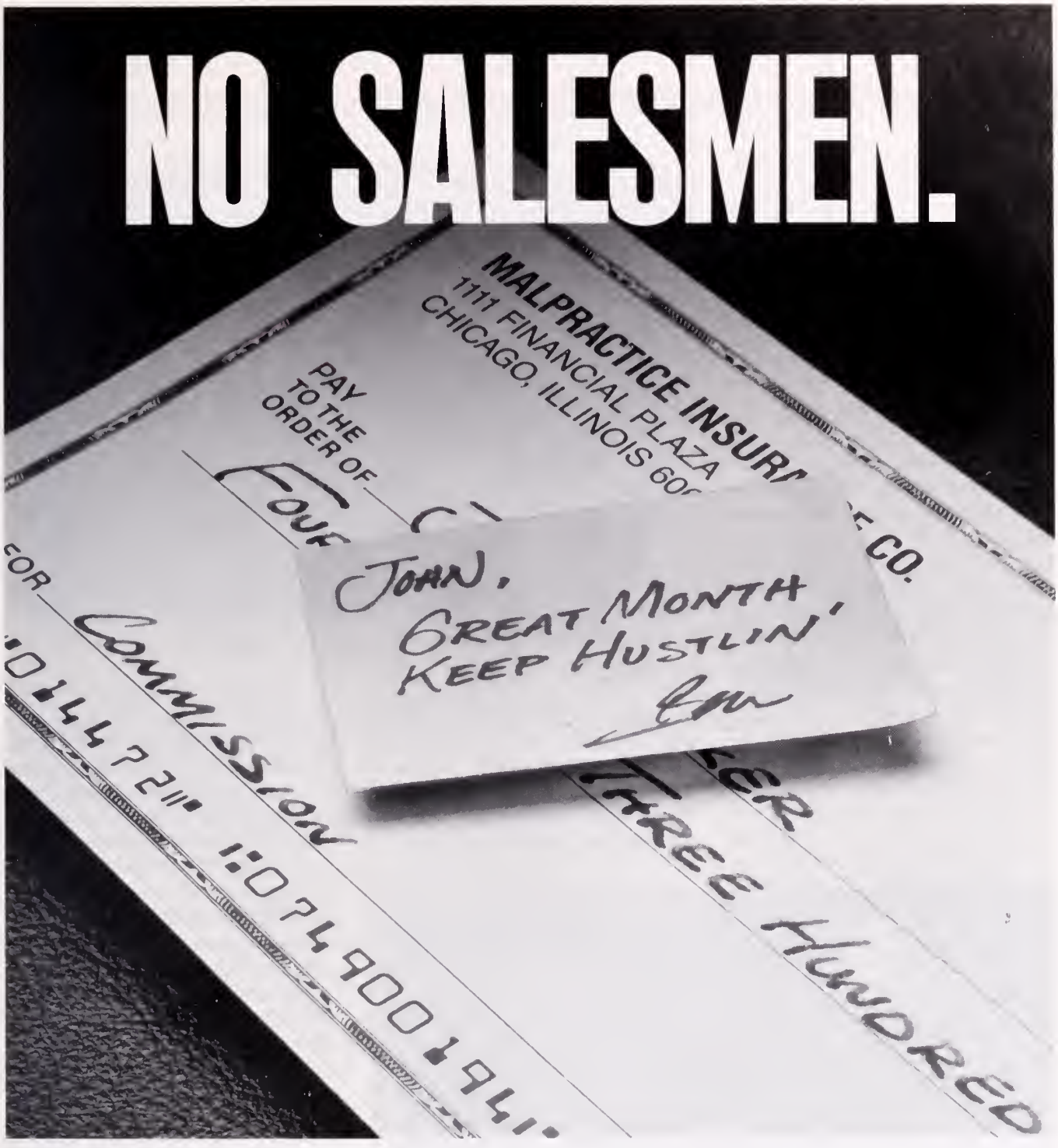
According to federal law enacted in 1989, states must document that rates paid for Medicaid obstetrical and pediatric care are high enough to attract a sufficient number of physicians into the Medicaid program so that patients have access to care equal to those not receiving Medicaid benefits. Failure to prove equal access for recipients could result in loss of federal Medicaid money in those areas of care, although that has never happened.

In its report, for example, the state certified, that in Waukesha County, 27 of 50 obstetricians provided Medicaid care, but the SMS and the OHCI could find only 25 obstetricians in the county, not all of whom provided care to Medicaid patients.

In explaining the discrepancies, the state says some obstetricians practice in more than one county and are counted twice. The SMS, however, said that alone would not account for the wide discrepancies.❑

Adams elected to national board

SMS SECRETARY-GENERAL MANAGER Thomas L. Adams, CAE, has been elected to the board of directors of the American Association of Medical Society Executives (AAMSE) at the group's annual meeting held in Minneapolis, Aug 22-25, 1991. AAMSE is a national association representing those involved in the administration of county, state and national medical societies. Adams will serve a 2-year term and will be eligible for re-election.❑



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SMS secretary-general manager heads north

AS PART OF HIS STATEWIDE physician outreach efforts, SMS Secretary-General Manager Thomas L. Adams, CAE, recently visited the Mariner Medical Clinic in Superior to discuss SMS efforts on Medicare and Medicaid, liability reform, and both state and national proposals for reform of the health care delivery system.

The Mariner Medical Clinic has attracted attention for its unusual location: inside a shopping mall. The clinic was created by the merger of three private practices in Superior and placed in the mall, according to the clinic administrator, Kevin Hayden, as an innovative way of providing convenient health care to the community and fostering steady growth of the physicians' practices. It has, in its first few years, proven successful at both, and Hayden attributes most of the success to the leadership the clinic's originator and president: Robert L. Sellers, MD.

The Mariner Medical Clinic and its retail neighbor in Superior.

The key to the clinic's success seems to be rooted in the medical staff's understanding that convenience is a shopping mall's strength and that they must make patient convenience the clinic's strength as well. The obvious convenience of being able to obtain health care and go shopping under one roof (particularly during northern Wisconsin's harsh winters) is not enough. The Mariner Medical Clinic has offered evening and weekend hours of operation, walk-in appointments, billing and insurance filing services, and a pocket radio pager for patients who would like to shop while they wait for their appointments. From the beginning, the clinic has made keeping patient waiting to a minimum a top priority and developed patient flow systems and centralized scheduling to serve the philosophy of "convenience medicine." And to reinforce the service and convenience themes in the minds of its patients, the clinic makes strong use of regular patient surveys in determining how satisfied the patients are with the clinic's location, level of privacy and mix of medical services.

The podiatry clinic affiliated with the Mariner Medical Clinic is located in the same mall.

Adams is available for meetings with physicians throughout the state and eager to hear what is on your mind. To arrange a meeting, contact the SMS Division of Public Affairs field staff at 1-800-362-9080 or (608) 257-6781.❑

Physician briefs

The * indicates a member of the SMS.

Richard A. Damon, MD,* of Sturgeon Bay, recently established a full-time practice in Door County. A family practitioner, Dr Damon received his medical degree from the University of Iowa Medical School and completed his internship at St Benedict's Hospital in Ogden, Utah.

Christine Petty, MD,* of Rockford, recently joined the Riverview Clinic and will be serving the Delavan facility. A family practitioner, Dr Petty received her medical degree from Stritch School of Medicine at Loyola University. Dr Petty completed her residency at Lutheran General Hospital in Park Ridge, Ill.

Michael L. Rainero, MD, of Whitewater, joined the Riverview Clinic in Janesville. A general surgeon, Dr Rainero received his medical degree from Rush Medical College in Chicago and completed his internship and residency at the Medical College of Wisconsin.

George H. Pfaltzgraff, MD,* of Richland Center, has begun his surgical practice with the Richland Hospital and Richland Medical Center. A graduate of Temple University School of Medicine in Philadelphia, Dr Pfaltzgraff completed his internship and residency at Good Samaritan Hospital in Cincinnati.

David Maruska, MD,* of Fond du Lac, has recently joined the Rosendale Medical Center. A family practitioner, Dr Maruska received his medical degree from the University of Wisconsin Medical School and completed a family practice residency at St Mary's Hospital in Milwaukee.

Michael A. Ganz, MD, of Racine, recently joined the staff at Racine Medical Clinic. Dr Ganz, an allergist, received his degree in internal medicine from the Chicago Medical School. He completed his internship and residency at the University of Illinois Hospital in Chicago.

Brady T. Welsh, MD, of Racine, recently joined the staff at Racine Medical Clinic. A family practitioner, Dr Welsh graduated from Baylor

Continued on next page

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION of the *Wisconsin Medical Journal*, issued monthly.

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EXTENT AND NATURE OF CIRCULATION

	AVERAGE NUMBER COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NUMBER OF COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
Total number copies printed (net press run)	7322	7078
Paid circulation (mail subscriptions)	7078	6931
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Free distribution by mail, carrier or other means (samples, complimentary, and other free copies)	90	90
Total distribution	7168	7021
Office use, left-over, unaccounted spoiled after printing	154	57
TOTAL	7322	7078

I certify that the statements made by me are correct and complete.
/s/DEBORAH BOWEN WILKE
Publisher

Date of filing: Sept. 4, 1991
PS Form 3526, modified above for purposes of printing

Continued from preceding page
College of Medicine. He completed his residency at Rush-Christ Integrated Program. Dr Welsh is board certified and has earned additional certification in geriatrics.

Steven Johnson, MD,* and **Gregg Kishaba, MD,*** of Eau Claire, recently joined the Midelfort Clinic. A general surgeon, Dr Johnson received his medical degree from the University of Wisconsin Medical School and completed his general surgery residency at Loyola University Medical Center in Chicago. Dr Kishaba, a pediatrician, received his medical degree from the Medical College of Wisconsin. He completed his residency at Children's Hospital of Milwaukee and for the past 3 years has been chief of pediatrics for the 812th Strategic Hospital at Ellsworth Air Force Base in South Dakota.

Jerome C. Brooks, MD,* of Racine Medical Clinic has been recently appointed as a member of the Department of Medicine, section of nephrology, at the Milwaukee County Medical Complex.

Bruce Ambuel, MD, of Brookfield, has been appointed assistant professor of family medicine at the Medical College of Wisconsin. He is currently director of behavioral sciences at the MCW Waukesha Family Practice training sites.

Sheree M. Lauth, MD,* of Clinton, has joined the Clinton Clinic. A family practitioner, Dr Lauth received her medical degree from St George's School of Medicine at Granada, West Indies, and completed additional training in England.

Gail M. McNutt, MD,* Richard K. McNutt, MD,* and **John G. Nemcek, MD,** have recently joined the Marshfield Clinic in Lakeland Center. Dr Gail McNutt, an allergist, earned her medical degree from the Medical College of Wisconsin. Dr Richard McNutt, a general-vascular surgeon, earned his medical degree at the Medical College of Wisconsin and completed a residency in general surgery in Milwaukee. The McNutts live in Woodruff. Dr Nemcek, of Minocqua, received his medical degree from the University of Wisconsin Medical School and completed a residency in internal medicine at Indiana University Medical Center in Indianapolis.

Robert C. Brickner, MD,* of Milwaukee, recently joined the Department of Endocrinology and Internal Medicine at St Luke's Medical Center in Milwaukee. A graduate of the Medical College of Wisconsin, Dr Brickner will begin a practice in endocrinology, diabetes and metabolism.

Laurence J. Marton, MD, has been named dean of the University of Wisconsin School of Medicine in Madison. A cancer researcher, Dr Marton is a clinical pathologist. Dr Marton received his medical degree from the Albert Einstein College of Medicine.

Robert W. Brown, MD, of Racine, recently joined the staff at the Racine Medical Clinic. A family practitioner, Dr Brown earned his medical degree at Baylor College of Medicine and completed his residency at Rush-Christ Integrated Program.

Jerome D. Fallon, MD, of Racine, recently joined the staff at Racine Medical Clinic. A dermatologist, Dr Fallon earned his medical degree at the University of Michigan Medical School and completed a fellowship at Massachusetts General Hospital and served his residency at Harvard Medical School.❑

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Internal medicine and obstetrics-gynecology practice opportunities. Rural lake country community is seeking the above practitioners to join an active 14 physician multi-specialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquiries to: Lake Region Clinic, PC, Attn: Joel Rotvold, PO Box 1100, Devils Lake, ND 58301 or call collect at 701-662-2157 for further information. 10/91

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 10-12/91

Family practice. Well established, eight-member primary group in central Wisconsin seeks another practitioner. Practice is located on campus of 210-bed hospital/long term care facility. Community setting is heavily geared toward creation and tourism. Four and one-half day work week and obstetrics is preferred. Excellent financial package including six figure salary, and bonus benefits with NO BUY-IN. For complete information, contact Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Rd, Suite 500, Atlanta, GA 30319, or call him at 800-347-7987, ext #1-138. 10-11/91

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' office 906-563-9255 or Dr William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870, 906-563-9243. 10-11/91

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 10-12/91

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 108-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Very competitive first year guarantee with benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, Michigan 49801; 800-323-8856. 10-11/91

Pediatrics-Marshfield Clinic, a 400-physician multi-specialty group practice, is seeking BE/BC pediatricians to join expanding regional centers in Chippewa Falls and Rice Lake, Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers, and streams. Both communities offer a thriving economic environment, clean air, low crime, excellent schools, and exceptional four season recreation. Chippewa Falls is a community of 22,000 with 8-10,000 permanent residents living around adjacent Lake Wissota. It borders Eau Claire, Wisconsin, a city of nearly 80,000 which includes a major campus of the University of Wisconsin. Rice Lake is a lakeside community of 8,500 people. In addition to excellent primary and secondary schools, both public and parochial, educational opportunities include a UW Center and VTAE campus. Both opportunities have beautiful new clinic buildings situated adjacent to comparably modern and progressive hospitals. In addition to their many local resources, the nearby proximity of major metropolitan areas (ie: 1 1/2 hours from Minneapolis/St. Paul) provides a catalog of readily accessible cultural activities, shopping, fine dining and professional spectator sports. Each opportunity has it's own special qualities with more attractive features relative to individual needs and preferences. Emphasis on life-style and quality practice is combined with a guaranteed salary and outstanding fringe benefit package. If this combination of professional excellence and life-style made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director Regional Development, 1000 North Oak Ave, Marshfield, WI 54449, or call 1-800-826-2345, extension 5376. 10/91

Lake Superior/boundary waters canoe area. Fulfilling opportunity is available on the picturesque north shore of Lake Superior for a family practice or internal medicine physician. Imagine scenic beauty, rugged terrain, various outdoor activities and time to enjoy it! If interested write: Jon Ward or Kathy Haselow, Silver Bay Clinic, 50 Outer Drive, Silver Bay, MN 55614 or call collect 218-226-4431. p10/91

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD,MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; ph 715-836-8552. 10-12/91

Pediatrician seeking energetic associate to join successful private practice. Two offices in Milwaukee and West Allis. Guaranteed salary with benefits. Send CV to Capitol Pediatric Care, 6110 W. Capitol Dr, Milwaukee, WI 53216, or call Sandy 414-462-3835. p10/91

Family practice & pediatric physician. Board certified/eligible. Exceptional opportunity to join a progressive and growing group practice in Milwaukee, Wisconsin. Competitive salary. Attractive benefits. Malpractice insurance. CME allowance. If you want to combine professional excellence with personal satisfaction, please send CV to: Mohammad Shafi, MD, Shafi Medical Center, SC, 2000 W. Kilbourn Ave, Suite C312, Milwaukee, WI 53233; 414-342-3000. 10,12/91

Private practice opportunities in Minnesota and Wisconsin. Dermatology, emergency medicine, ENT, internal medicine, family practice, obstetrics/gynecology, ophthalmology and pediatrics. Join established groups with strong hospital support in attractive communities. Contact: Jerry Hess, Abbott Northwestern Hospital (16501), 800 East 28th St, Minneapolis, Minn 55407; ph 1-800-248-4921. A lifeSpan member. 9-11/91

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BOXED AD RATES: $30 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg*, copy for the August issue is due July 1.

SEND TO: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Physicians Exchange

Continued

Madison,Wisconsin-Urgent Care. Dean Medical Center, a 220+ physician multi-specialty group, is seeking two urgent care physicians to join its six member urgent care department. Qualified applicants should be BE/BC in internal medicine, family practice or emergency medicine with experience in pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 am - 11:00 pm. All physicians rotate between both sites and work an average of 40 hours per week. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715 at work 608-252-8022 or home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Osceola on the river St. Croix. Ladd Memorial Hospital and Ramsey Clinic-Osceola are seeking out a family physician to join the well established local group. Osceola, Wisconsin, is situated on the bluffs of one of mid-America's most beautiful waterways, the river St. Croix. Osceola is located 40 minutes northeast of the Minneapolis/St. Paul metropolitan area. This practice opportunity truly offers the perfect balance! For particulars, forward your curriculum vitae or contact: Loriese A. Stoll, Director of Professional Services, Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101; or call collect 612-221-3067. 9-10/91

Madison, Wisconsin. Dean Medical Center, a 220 physician multi-specialty group is seeking three additional family physicians to join its 30 member department. Positions are located at the Arcand Park and West Madison locations, obstetrics is required. Madison is the home of the University of Wisconsin with enrollment of over 40,000 and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits is provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Physician Recruiter, Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715; work 608-252-8022 and home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Platteville, Wisconsin. Excellent opportunity for a family physician to practice the full range of medicine including obstetrics and join a four person well established family practice group. This is affiliated with Dean Medical Center a 220 multi-specialty group based in Madison, Wisconsin. Platteville is the home of the University of Wisconsin, Platteville, with enrollment of over 5,000 and the Chicago Bears summer training camp. Excellent salary and benefits. Educational loan payment assistance is negotiable. For more information contact Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715; work 608-252-8022 and home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Madison, Wisconsin. Dean Medical Center, a growing 200 physician multi-specialty group with over 18 locations is seeking two additional BE/BC internists to join their 25 member department. Madison is the home of the University of Wisconsin with enrollment of over 40,000 and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Physician Recruiter, Dean Medical Center, 1313 Fish Hatchery Road, Madison, WI 53715, work 608-252-8022 and home 608-276-8989. An Equal Opportunity Employer. 9-10/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Family practice and internal medicine opportunities for BC/BE physicians to join progressive primary care satellite clinics in Barron and Chippewa Falls, Wis. These clinics are part of the Midelfort Clinic, a multi-specialty clinic in Eau Claire, Wisconsin, which is owned

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Obstetrician/Gynecologist, Ashland, Wis. Medical Associates North, a progressive 17 physician multi-specialty group is currently seeking a BC/BE obstetrician/gynecologist. Current staff includes two Ob/Gyns, 7 FPs, 4 IMs, 1 Ped, and 3 EMs. Extremely competitive salary plus full benefit package. Outstanding quality of life on the shores of Lake Superior. Exceptional school systems, recreational offerings, and clean air! Contact Randy L. Munson at New Physicians for Wisconsin, University of Wisconsin-Office of Rural Health, 5721 Odana Road, Madison, WI 53719; 608-273-5964 COLLECT. 9-12/91;1-2/92

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Lake Mills Medical Center, SC

One or two Family Practitioners wanted, board certified or eligible. This is a golden opportunity in an ideal setting, located between Madison and Milwaukee on beautiful Rock Lake in a growing community. A modern, fully equipped hospital close by with full specialty backup but no restrictions to the well trained practitioner. Please call Lake Mills Medical Center, SC, c/o Dr. James P. Wishau, phone (414) 648-2391, for further information. 9-10/91

Physicians Exchange

Continued

and managed by the physicians. An outstanding two year guarantee, bonus, and comprehensive benefit package are being offered. Barron and Chippewa Falls are communities with excellent school systems, wonderful outdoor recreation and quality family life. Close to both Eau Claire and Minneapolis/St Paul, these positions are available due to community growth and demand. Please contact Debbie Bakula, Caswell/Winters, 11400 W. Lake Park Dr, Milwaukee, WI 53224; ph 1-800-236-0488. 9-11/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Family practitioner and internist to join well established and respected multi-specialty group, with excellent patient base. Our nine physicians practice high quality care, in suburban city located 15 minutes from Milwaukee. Competitive, guaranteed first year salary, with production bonus, plus excellent fringe benefits. Send CV to: Michael Lamping, Clinic Manager, South Milwaukee Clinic, 100 15th Avenue, South Milwaukee, WI 53172; ph 414-762-3680. p9-10/91

Baraboo, Wisconsin. Seeking internist, family practitioner, general surgeon and emergency department physician. Growing practices require additional physicians in a beautiful, growing rural community. Contact Thomas Warwick, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608-356-1400. 5-10/91

Internal medicine. The Racine Medical Clinic a 42-physician multi-specialty group conveniently located between Chicago and Milwaukee. Well-equipped all new clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to: RD Lacock, Administrator, Racine Medical Clinic, 3807 Spring St, Racine, WI 53405. 7tfn/91

We are seeking a Board-eligible Ob/Gyn and an internist with or without subspecialty interest to join a well-established nine-physician expanding multi-specialty group. Location is in a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Full status in-service corporation with shared overhead and an incentive-oriented formula after the first year. Please contact David Lawrence, MD, 92 E. Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/90

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Beloit Clinic, SC, an expanding 45 physician, multi-specialty group in southern Wisconsin college town, is seeking a plastic surgeon, pulmonologist, a rheumatologist, an OB/GYN, and orthopaedic surgeon, a pediatrician, a physiatrist, and urgent care. Guaranteed salary with incentive, plus excellent fringe benefits. Send CV to James F. Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 8-10/91

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Madison, Wisconsin 180 member multi-specialty group seeks BC/BE Family Practitioners for several locations. Call groups ranging from 4-7 physicians. Obstetrics required. Competitive guaranteed salary and comprehensive benefit package. Shareholdership available after two years. Excellent school systems, recent survey ranked Madison the eighth most desirable city to live in in US! Contact: Laurie Glowac, Physicians Plus Medical Group, 345 W Washington Ave, Madison, WI 53703 or call collect: (608) 252-8580. p10/91

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Physicians Exchange

Continued

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary incentive bonus, plus paid health, life, malpractice, 401K. Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV: G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

Internist needed to join one of the leading internal medicine practices in Kenosha, Wisconsin. This is an opportunity to build a strong and vibrant practice within the first one to two years. Office conveniently located on the hospital campus. Kenosha provides an excellent quality of life: many choice yet affordable places to live, superior schools, proximity to recreational facilities, and central location less than one hour from either Chicago or Milwaukee. Compensation competitive including an incentive plan which provides enhanced earning potential. Contact Jan Channon (708) 945-7717 or send CV to 1855 Deerfield Road, Suite 2300, Highland Park, IL 60035. 10/91

Physicians Exchange

Medical Director. Primary care clinic immediate opportunity. 7:30-4:00 Mon-Fri. JSA Healthcare Corp. is looking for a primary care physician to direct and service the Troop Medical Clinic at Ft. McCoy, located in Sparta, WI. The clinic provides healthcare to active duty personnel, dependents and occ. Health services to Ft. McCoy. Position requires a MD or DO, with ambulatory care experience, current license in one of the fifty states and ACLS/BCLS. Competitive financial consideration is offered with paid malpractice/CME. No nights-no call-no weekends-no holidays!!! Contact Susan Bray 1-800-966-2811. 10-11/91

For Sale

For sale. Medical clinic building near Meriter Hospital, Madison. 11,200 sq ft, 3 floors, elevator, attractive brick and glass. Lots of parking, excellent bus service. Priced well below replacement and assessment. Asking $449,500. All offers considered! 608-255-6787 Keller Realtors. 10/91

FOR SALE - Milwaukee, WI Office and home. Includes 200/110 Philips x-ray, word processor programmed for insurance forms, etc. and other necessary office equipment. Office built directly in front of home. Step right in and enjoy! Should see to appreciate. Kept in very good condition. Only business on block affords very good visibility. Selling only because of disability. 4476 N. 60th St. Call afternoons. (414) 466-6565. Priced to sell, $79,900. p10/91

Medical Meetings-Continuing Medical Education

November 1, 1991: "Rush Symposium on Hepatic and Biliary Disease," at Rush-Presbyterian-St. Luke's Medical Center, Chicago. Presentation format will focus on current issues in the management and treatment of liver disease patients. Fee: $150. CME credit applied for. Info: Suzanne Buss, Physician Relations Coordinator, ph 312-942-6242. 10/91

December 11-13, 1991: "Neurology for the non-neurologist," at The Westin Hotel, Chicago, Ill. Contact: Office of Continuing Medical Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago, IL 60612; ph 312-942-7095. 9-10/91

AMA

December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

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A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk, therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Contents

November 1991 Vol. 90 No. 11

Opinions

615 *President's page*
The challenge to health insurers
'Medicina nusquam non est' (medicine is universal): VI
by Cyril M. "Kim" Hetsko, MD, Madison

616 *Secretary's report*
Riding the storm out
by Thomas L. Adams, CAE

618 *Voice of the SMS*
Where there's smoke, there's fire

620 *Letters*
Physicians must clean their own house
by A. Yale Gerol, MD, Kenosha

622 Factors in the economics of health care
by Walter Lewinnek, MD, Merrill

626 *Soundings*
The ideal physician (personal observations)
by William J. Maurer, MD, Marshfield

Scientific

627 But it just looked like an insect bite...
A case of myiasis in Wisconsin
by Mark K. Chelmowski, MD, and James L. Troy, MD, Milwaukee

628 Ulnar neuropathy caused by an accessory abductor digiti minimi muscle
by Joseph E. Sheppard, MD; Thomas B. Prebble, MD; and Kevin Rahn, MD, Ft Wayne, Ind, and Marshfield

632 Diagnostic dilemma for the 1990s: Lyme disease versus rheumatic fever
by Andrea Dlesk, MD; Arpy A. Balian, MD; Bradley J. Sullivan, MD; Paul D. Mitchell, PhD; and James J. Marx, Jr, PhD, Marquette, Mich, and Marshfield

Socioeconomic

635 *Public health*
ASSIST Wisconsin
by Patrick L. Remington, MD, and Robert Greenlaw, MD, Madison and Marshfield

639 News you need on Medicare

639 Public health column gains national attention

Organizational

641 Highlights from the October Board of Directors meeting

641 SMS helps land $6.5 million contract for anti-smoking project

642 SMS supports bi-partisan health insurance reform proposal

645 Senior physicians' group meets in Madison

645 SMS secretary-general manager travels to the northwoods

646 Physician briefs

648 County society news

652 Obituaries

655 CES Foundation donors

Our cover: The SMS joined with the Wisconsin chapter of the American Cancer Society to create an advertisement with a similar design and this message, and to place it on buses in metropolitan Milwaukee during November.

Wisconsin Medical Journal

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

The challenge to health insurers

'Medicina nusquam non est' (medicine is universal): VI

Cyril M. "Kim" Hetsko, MD

As we consider our obligations for building access to cost effective, quality medicine, the critical role of the insurance industry must be recognized.

In recent years, the sales of first-dollar health insurance coverage has effectively eliminated the individual from having an economic incentive to use medical services cost effectively. Americans have wanted "somebody else" to pay for their care, while they want unlimited immediate access to the most advanced care. The patient need to have some type of economic interest in the use of their health care system. Insurance employers and unions have, in recent years, just begun to reconsider co-pays, deductibles, and subscriber accounts (with unused balances being returned to the individual insured).

The health insurers have often thrown up their hands and absolved themselves by saying that health care cost increases are merely being passed through. This industry, however, has shown little inclination to return to the basic premise of insurance: To widely share the risks we all face. Stated a bit differently, a large number of insured people pay into a fund to protect the unfortunate few who have claims to pay.

Recently, we have seen the health insurance industry advance the art of medical underwriting to new heights. Very strict exclusions have been applied for pre-existing conditions, with the denial of coverage for new policies, and great increases in the premiums for those who had claims. A significant number of the uninsured people in this country are a result of these industry practices.

Physicians would like to work with the insurance industry to move away from these systems of underwriting, which often deny coverage to those who need it the most. Immediate reforms are needed to move to community underwriting, to assure portability of insurance between jobs and when laid off, and to make the system administratively simple.

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Continued from preceding page

The insurance industry expects physicians and health care providers to be "cost effective" through a number of techniques (including "managed" or proctored care, concurrent and post-payment reviews, and payment denials). It is time, however, that this industry also becomes leaner, with the elimination of the high retained premiums and exorbitant commissions for its agents, and become responsible for some of the excessive salaries and perks of some of its executives.

We must all accept our obligations to ensure that access to quality medicine is preserved for all the citizens of this great state as cost effectively as possible. Physicians and insurance companies must jointly work toward these goals.❑

Secretary's report

Riding the storm out

Thomas L. Adams, CAE

THE OMINOUS CLOUD you see on the horizon is the thunderhead of Medicare "reform," and it's headed our way. The new year will witness the most dramatic and far-reaching changes in history of the Medicare system. In an era when the federal government is looking for cooperation from the medical profession to reshape the entire health care delivery system, it is disappointing that is has broken faith with the medical profession and the American people. The approaching storm is likely to disrupt your practice, your office staff and your patients, and while the Society cannot solve all of these problems for you we want to help as much as we possibly can.

To avoid being swept away by the storm, you need information. The Society has put together a plan to make as much information available as quickly as possible. Last month, *Medigram* began running a series of stories on the Medicare changes, and you should closely monitor *Medigram* for regular updates. If you miss them there, you will find them repeated in the *WMJ* (see p 639 of this issue).

The final rules implementing the RBRVS, which came out in the first week of November, will be summarized and distributed to all SMS members as quickly as possible through *Medigram* and special mailings. Throughout the fall and into the new year, we will use these same vehicles to provide instructions to help you tackle additional key problems.

The Society has worked with the Wisconsin Medical Group Management Association to help coordinate 10 physician-only seminars, led by Kay Jewell, MD, WPS-Medicare medical director, that are now being held throughout the state. The Society's own fall Medicare seminars have included 1,670 physicians and their staffs, and we have created two additional programs in response to overwhelming demand. Another round of Medicare seminars is scheduled for February 1992. Watch *Medigram* for further details.

Meanwhile, the SMS is holding weekly meetings with WPS to discuss and, we hope, remedy implementation problems as the arise. We will also hold two December seminars to acquaint insurers with the new visit codes and the new HCFA 1500 claims form.

I must ask, however, for your patience and understanding. I expect the Society to field an overwhelming

Continued on page 618

Statewide Physicians Health Program speakers available

The SMS Statewide Physicians Health Program (formerly, the Statewide Impaired Physicians Program) has speakers available to address county medical society meetings and other groups of physicians. For more information, contact Sally Wencel, JD, at 1-800-362-9080 or (608) 257-6781.❑

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Continued from page 616
number of questions from physicians, insurers, patients and reporters, and we will respond to the best of the abilities of our limited staff and resources. I predict that the volume of demand for our assistance may cause some delay in our responding to your inquiries, and I would like to thank you, in advance, for your tolerance.

Wisconsin's physicians and their State Medical Society have, in their 150-year history, endured some tough times before. With a little patience and a lot of work, we will get through this, too.

* * *

The cover of this issue of *WMJ* reproduces part of the signs the SMS and the Wisconsin chapter of the American Cancer Society created and placed on buses in metropolitan Milwaukee. The ads will run during November, while the Philip Morris-sponsored tour of the Bill of Rights is in town. Please see the related editorial below and the public health column on page 635.□

Voice of the SMS
Where there's smoke, there's fire

AS YOU MAY HAVE already heard, the Philip Morris company has brought the US Bill of Rights to Wisconsin this month as part of a national tour. This hallowed document is on display at the MECCA in Milwaukee, and the SMS encourages everyone who can to stop in and see it. We would be hard pressed to name a piece of writing that contains more profound wisdom and more enduring beauty. The dreams, the convictions and the values spelled out by our founding fathers deserve the contemplation of every American. What a shame, then, that its display is, in our opinion, being cheapened by use as an apparent marketing gimmick to help sell tobacco products that undermine the public health.

Philip Morris has been distributing a brochure that boasts of how its subsidiaries (mostly non-tobacco related companies) employ more than 7,000 people in Wisconsin. This economic leverage was one of the tools it used to persuade the governor to veto the 10-cent tax on tobacco products from the last budget bill. But let's consider what other influences Philip Morris has in Wisconsin.

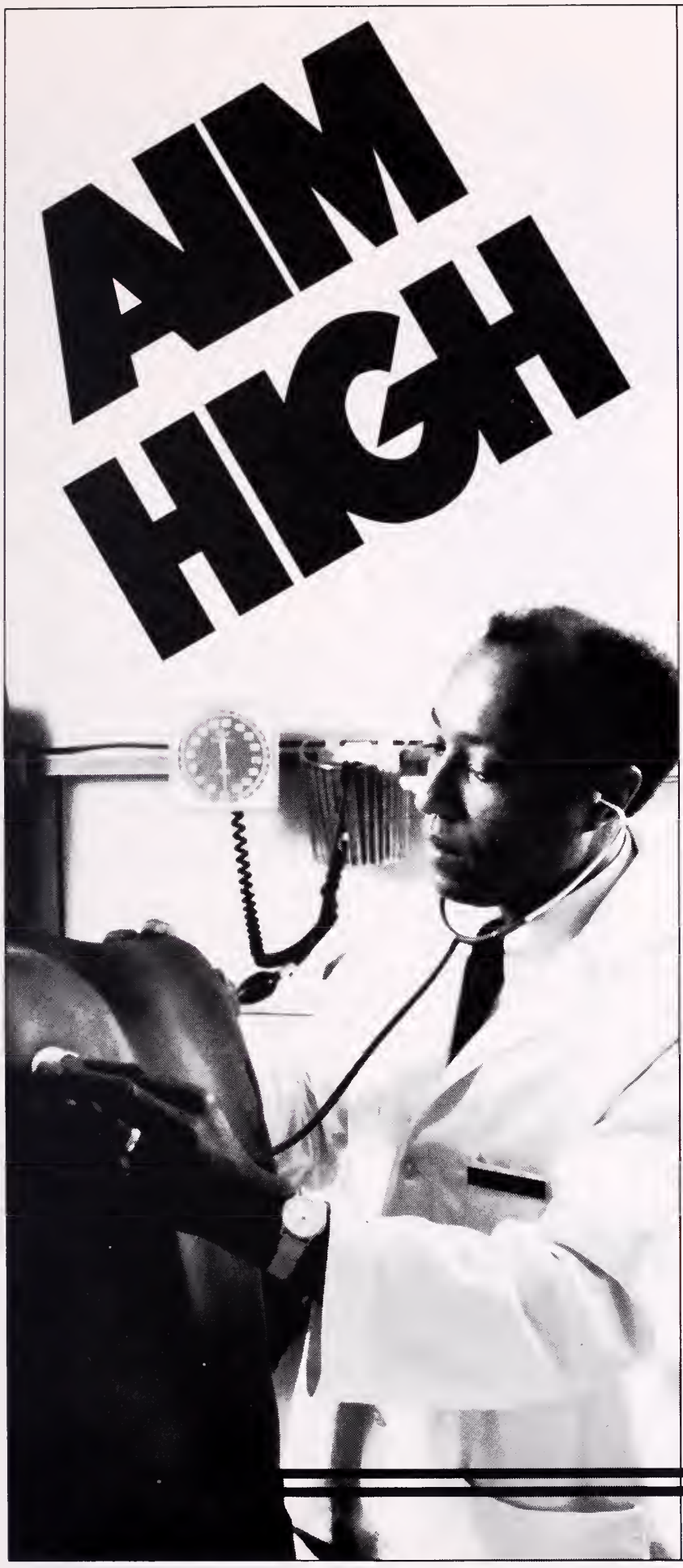
The Wisconsin Division of Health attributes 7,900 deaths per year to the effects of smoking (*Wis Med J.* 1990;89(11):646-651). The direct and indirect economic losses suffered by Wisconsin and caused by smoking are estimated at $868 million per year. (Louis Sullivan, MD, secretary of US Health and Human Services, puts the national tolls at more than 365,000 lives and $52 billion every year.) It could be argued that Philip Morris, accounting for about 40% of the tobacco market, should be held at least being partially responsible for the annual loss from smoking of 3,160 lives and $347.2 million in Wisconsin. It could be argued that Philip Morris tobacco products help cause the death, every 2.5 years, of as many Wisconsin residents as Philip Morris subsidiaries employ. And unless these subsidiaries are paying astronomical salaries, they cannot begin to counter the annual economic losses ascribed to smoking.

What is to be done? Obviously, the SMS does not have the resources to match the expenditures of a company the size of Philip Morris, much less the entire tobacco industry, in either a political or a public relations war. The industry has a tremendous record of political victories at the federal level and an impressive record at the state level. But a study published by a recent issue of the *Journal of the American Medical Association* has found that attempts to curb smoking are far more successful when made in our local communities. More importantly, local physicians are the key to this success. The authors concluded that, "Despite the tobacco industry's superior financial resources, enactment of a specific local (tobacco control) ordinance depends not on the tobacco industry but on how seriously the health industry advocates mobilize in support of the legislation."

We note with pride that the Wisconsin Legislature has been–with SMS prodding and support, and despite the lobbying power of entities such as Philip Morris–one of the most progressive in the nation when it comes to tobacco issues and protecting the rights of non-smokers. The Clean Indoor Air Act is a good example. Credit is due, too, to the governor, who has pledged his support for a 5-cent tax increase on cigarettes. The SMS will vigorously pursue this bill because it can accomplish the twin goals of reducing tobacco consumption and providing revenue for health care programs.

Dr Sullivan correctly characterized the loss of life and economic strength

Continued on page 620



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Continued from page 618
to smoking as a "tragedy." The only question is: What are we going to do about it? Schools, churches and professional associations–such as the SMS, AMA, American Cancer Society, American Lung Association and American Heart Association–continue to work on public education, but these efforts can go only so far. Health care professionals, physicians in particular, hold a much more powerful weapon. Our patients trust us with their lives and the lives of their families. We, as physicians, have the credibility, expertise and opportunity to effectively reach smokers and potential smokers. We also have the credibility, expertise and community standing to provide leadership at the local level, where it is apparently most productive.

If that sounds like we're asking a lot of you, we are. But so did the founding fathers. Reading the Bill of Rights, you get the message that the authors expected us to be participants, not spectators. They expected us to give of ourselves. They expected that we common men and women to find the nobility within ourselves and rise to meet even those challenges that appear to be insurmountable. And they expected us to cherish the opportunity.❑

Letters
Physicians must clean their own house

TO THE EDITOR: I read the article in the August *WMJ* about Kevin Fullin, MD, and I applaud the work of Dr Fullin and his colleagues and the thousands of other physicians who work tirelessly and namelessly for their communities. Their sacrifices can never be repaid. But in the same issue of the *WMJ*, there is a letter from James P. Fogarty, MD, decrying the WIPRO program and the involvement of WIPRO with the quality of medicine.

It occurs to me that the reason for the AMA's MD 2000 Program is attempting to reverse the increasing dismay of the public with the medical field. If spin control is the goal, the thrust of the advertising campaign is bankrupt.

The public is unhappy with physicians because it is increasingly convinced that physicians are paying more attention to the business of medicine than to the treating of their patients.

The thrust of the AMA, as well as of the SMS, should be to publicize that the physician's motto is "Do only the right thing and only do it right." Each physician should be dedicated to establishing the parameters of high quality medicine and to ensuring that these parameters are met by every single practicing physician.

We should publicize that medicine is being policed by those who know medicine best–physicians–and that the abusers will not be permitted to practice. We should publicize that the majority of physicians would not tolerate either the 14% of physicians who are impaired or the 10% who are,

Continued on page 622

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

July 1991

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Continued from page 620
in the words of the federal government, felons and frauds. We should publicize that ignorant, incompetent doctors should not be allowed to practice.

Any physician reading this–if this is ever printed–will agree that there are physicians practicing in his or her hospital to whom he or she would not send his wife or his child because he or she knows that these physicians are incompetent. We should weed them out, but our current practices tolerate the incompetents. Wee know that there are physicians abusing the HMO and PPO systems, but we are silent. This golden silence is recognized outside of medicine, which makes it easy for politicians to snipe at us. Rep Pete Stark (D-Calif) can point his finger at us and say that physicians are in business, and that physicians should not own diagnostic or imaging services because they are over-used, and he is correct.

As long as this silence about the lack of medical talent of some physicians, about the absence of personal rectitude of some physicians, about the resistance to measurement of the quality of care persists among physicians, all doctors will be considered suspect. As more physicians become suspect, more political, external, nonmedical structures will be placed on the profession.

We must clean our own house, and until we do no amount of expensive publicity illustrating the sacrifices of physicians will ever reverse the fact that patients don't trust us to do only the right thing and do only the right thing right.

–A. Yale Gerol, MD
Kenosha

Editor's note: This letter has been edited to meet length limitations.❑

Factors in the economics of health care

TO THE EDITOR: I have followed Dr Hetsko's "Medicina Nusquam Non Est" essays with interest and with approval of his views. In particular, I applaud his initiative as spokesperson of organized medicine in Wisconsin to work with business and industry on the fiscal aspects of our health care system. There are, however, additional factors, perhaps more fundamental than those presented by Dr Hetsko. I submit the following concerns:

Demographics

According to figures published by HCFA (the last ones available are from 1987), the total US population is, in round numbers, 246 million. Of these, 71 million are under the age of 19, and 30.5 million are 65 or older, or a total of 101.5 million before and after the peak earning years. Not all of the remaining 144.5 million are in the work force; assuming, however, that the numbers would be balanced by those under 19 and over 65 who do work, and then applying an optimistic 7% unemployment rate, we arrive at something over 134 million income-producing population *v* 112 million to be sustained.

Continued on page 624

WMJ Writing Contest

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Deadline: Papers must be received by the *WMJ* by Feb. 14, 1992: PO Box 1109, Madison, WI 53701.

Rules: Papers must be typewritten, double-spaced with 1-inch margins, and no longer than 10 pages. Topics must fall within the parameters of scientific medicine. The *WMJ* editorial board serves as the panel of judges and has final authority.

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Continued from page 620

The numbers are skewed by the large contingent of marginally employed individuals who are not eligible for health benefits in any category and contribute little in buying power, including health care. The imbalance is further aggravated by the fact that the older age group is a disproportionate consumer of medical and hospital services.

Attitudes and opportunities

Large segments of the population do not understand, are not aware of, or reject as inconvenient, the benefits of wellness programs and other preventive measures. It is unfortunate that funds are being cut for public health departments at all levels, and such funds as are made available, are not put to optimal use. I would advocate a revamping of the public health system, with a goal of retaining proven specific programs, but emphasizing educational and outreach aspects.

Fragmentation

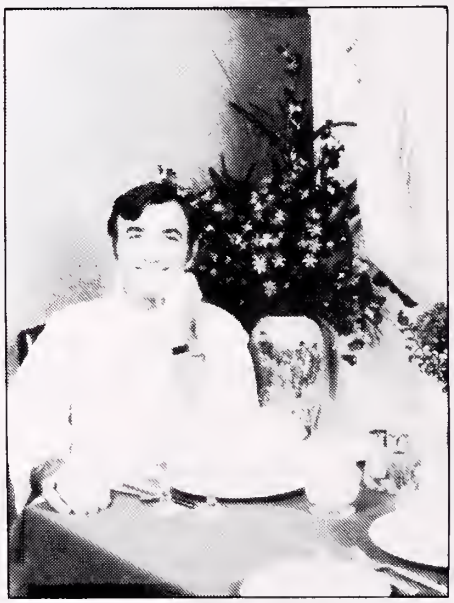
Dr Hetsko mentioned diversity in his July essay as a positive force that makes our system work. I can agree up to a point. But diversity is counterproductive when the administrative and regulatory apparatus proliferates, and when it generates the need for costly compliance mechanisms. Multiple governmental programs from AFDC to WIC, the hybrid Blue plans, and a free-wheeling private insurance industry, have not been able to stem the tide but have rather compounded the problem.

Physician responsibility

We fought Medicare, then made the most of it. Comprehensive health care will be the domestic political issue in 1992. It behooves the medical profession to cooperate with responsible members of Congress to formulate a proposal without administrative excesses and with safeguards against abuse. I know that that will not be easy. And I also know that implementation will not be possible without a price tag.

–Walter Lewinnek, MD
Merrill❑

Peppino's



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Soundings

The ideal physician (personal observations)

HAVING BEEN A WISCONSIN physician for 30 years and having a son in medical school has inspired me to get my thoughts together to give advice and recommendations to interns and young physicians as to the expectations and attributes that will help them become the ideal physician.

I am a member and former president of the largest group practice in Wisconsin. I have had the opportunity to be involved in the selection and evaluation of many physicians joining our group practice. I have observed many physicians and judged their degree of success and have seen where a lack of some attributes have caused difficulty for them, their patients, and their clinic.

I feel that those who choose to follow the path presented here will have the greatest success and personal satisfaction as a member of the profession.

I have divided my analysis of the ideal physician into professional and personal attributes. The field of medicine is very broad and these comments are directed more closely to a physician involved in clinical medicine.

One classification of a physician's involvement in medicine may include patient care, teaching and research.

Today's practice takes care of current problems, but if we wish the future to be better some of us need to be involved in teaching our future doctors and in research. While there are many excellent physicians who simply practice medicine, I would give a noticeable edge to those who are also involved in either teaching or research.

For those who are involved in the current care of patients, it is necessary to be scientifically oriented and to continue one's medical education by reviewing the medical literature.

I have found that for a physician to stand out he or she should be involved in the organization and management of medicine. This includes involvement in organized medicine and in professional societies. Community involvement should also be encouraged.

Personal attributes include, first and foremost, honesty and dependability, with a willingness to do one's fair share and to give of one's self. An attention to detail is essential.

The ability to get one's priorities straight is of the utmost importance. By that, I mean obtaining one's personal rewards from the satisfaction of the practice, intellectual stimulation, and relationships with patients and colleagues–not from the financial aspects of the practice of medicine.

Finally, and most importantly, a clinical medical practice needs to be accessible, available, dependable and timely. One must have empathy and compassion for the patient and to maintain moral character in relationships. It is especially important to be helpful to patients without being judgmental about all of their actions.

If you are and do all of these things, you will automatically be hard working. You will need to make some accommodations with all of these high standards and ideals in making sure that you have some recreational time and time for your family–although these should not be your first priority.

I personally have not been able to meet all of these standards. Perhaps if the goals had been better defined the road might have been easier. I have had the pleasure of knowing many physicians that have met many or most of these standards, and some that I believe have come very close to being the ideal physician. I think that if we do not try to define our standards and expectations, it will be more difficult to meet the goals.

–William J. Maurer, MD
Marshfield❑

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But it just looked like an insect bite . . . A case of myrasis in Wisconsin

Mark K. Chelmowski, MD, and James L. Troy, MD, Milwaukee

A 46 YEAR-OLD WOMAN went to Costa Rica and spent 3 weeks conducting research in the tropical rain forest. One week before leaving, she noticed a few spots of blood on the sleeve of her shirt over her right shoulder. Two days later, serosanguinous drainage was noted from a small puncture wound in the shoulder. She sought medical attention upon return to Wisconsin. At this time, there was a 1.5 cm area of swelling with a central red papule present. The lesion was excised. Microscopic examination revealed was no evidence of any foreign body, insect remnants, or granulomas. The inflammatory cell infiltrate was nonspecific, but suggestive of an insect bite reaction. Four days later, the patient had a sensation of movement in the wound, and it was incorrectly attributed by her physicians to a loose piece of subcutaneous suture. She was re-examined twice, and no other abnormalities were found to account for the sensation of a moving foreign body in her shoulder.

Four weeks after her return to Milwaukee from Costa Rica, a 1.5 cm larva crawled out of the shoulder wound (Figure). It was identified by Allen M. Young, PhD (curator of zoology at the Milwaukee Public Museum) as the larva of the human botfly, Dermatobia hominis. The larva was observed at the museum but died before maturing into the botfly.

The patient's wound quickly healed and her dismay and revulsion gradually subsided. She is again planning to travel to Costa Rica on another scientific expedition this summer.

Discussion

The invasion of living, necrotic, or dead human or animal tissue by the larvae of flies is termed myiasis. The fly Dermatobia hominis is found in Mexico, Central American, and tropical South America.[1] The fascinating life cycle of this insect begins as the adult female botfly captures a mosquito and glues its eggs to the body of the mosquito. When the mosquito bites a bird or mammal, the botfly's

Figure–Dermatobia hominis larva. This photograph was taken by the patient after the larva crawled out of her shoulder.

Dr Chelmowski and Dr Troy are with the Milwaukee Medical Clinic. Reprint requests to: Mark K. Chelmowski, MD, Milwaukee Medical Clinic, SC, PO Box 17300, Milwaukee, WI 53217. Copyright 1991 by the State Medical Society of Wisconsin.

eggs fall off and penetrate the host's skin. The larvae penetrate into subcutaneous tissue, and over the next 6 to 8 weeks grow to a size of 18mm to 24 mm. Mature larvae then emerge from the skin and fall to the ground to pupate.

Myiasis usually causes furuncle-like lesions in the skin which resolve once the larva extrudes itself. Larvae may enter the vaginal and urinary tract, the nasopharynx, sinus, eyes, and auditory canals, causing more complicated local disease.

Considerable knowledge of myiasis was gained when an entomologist in Panama, L.H. Dunn, allowed 6 larvae to enter and develop in his own arms and legs.[2] He chronicled three sensations with the presence of these larvae over the ensuing 54 days. There was intense itching of the skin in the area surrounding the lesion thought to be due to a slight cellulitis from the feces of the larva. An irritating pin-pricking sensation was attributed to the rasping of the cutaneous spines of the larva during movement. Sharp stinging pains were thought to be caused by the larva's oral hooks tearing tissue to produce blood and serum, which served as food.

Treatment of cutaneous myiasis includes deep excision, with care being given to not leave any fragments of the larva behind. Excision, however, may miss the larva which has penetrated deep into subcutaneous tissue. Injecting 2 mL of lidocaine beneath the nodule can create enough pressure to push the larvae out through the skin, anesthetically.[3] Another option is occluding the punctum of the site of the bite in the skin with Vaseline, shortening, or butter, forcing the larvae to extrude itself to breathe.[4]

Conclusion

Myiasis should be considered in any patient who has traveled to an endemic area and returns with a non-healing furuncular lesion. Associated sensations of itching, pricking, or of movement in the lesion support the diagnosis. Early recognition and treatment can provide quick symptomatic relief and will also decrease patient anxiety and distress.

References

1. McIntyre FL. Myiasis. *Am J Fam Pract.* 1989;39:129-131.
2. Dunn LH. Rearing of the larvae of Dermatobia hominis in Man. *Psyche.* 1930;37:327-42.
3. File TM, Thomson RB, Tan JS. Dermatobia hominis dermal myiasis. *Arch Dermatol.* 1985; 121:1195-1196.
4. Nunzi E, Rangioletti R, Rebora A. Removal of Dermatobia hominis larvae. *Arch Dermatol.* 1986; 122:140.❑

Ulnar neuropathy caused by an accessory abductor digiti minimi muscle

Joseph E. Sheppard, MD; Thomas B. Prebble, MD; and Kevin Rahn, MD, Little Rock, Ark, Ft Wayne, Ind, and Marshfield

Peripheral neuropathies of the ulnar nerve at various locations in the upper extremity are common,[1] but compression of the ulnar nerve at the level of the wrist due to an anomalous muscle is rare, though reported in the literature. Three cases of an abnormal abductor digiti minimi origin were first reported by Wood in 1868,[2] but no mention was made of an associated ulnar neuropathy. To date, there have been 8 reported cases of an anomalous abductor digiti minimi, with sensory or motor abnormalities of the ulnar nerve the most common presentation.[3,4,5,6,7]

This case report describes a patient who had subjective paresthesiae in the ulnar nerve distribution for 2 years. He was found, at exploration, to have an anomalous muscle belly originating proximally from the deep forearm fascia with insertion into the abductor digiti minimi. We present the case, discuss the spectrum of compression neuropathies of the ulnar nerve at the wrist, and a review of the occurrence of anomalous muscles responsible. *Wis Med J.* 1991;90(11):628-631.

In June 1986, a 32-year-old man noted paresthesiae involving the volar aspect of the distal portion of the right ring and little fingers. There was no associated weakness, muscle atrophy or hypothenar pain. Six months later, the patient noted that the ulnar aspect of the hand became painfully cold while outdoors. There was no clear Raynaud's phenomenon, although on several occasions the hand was noted to have a mottled appearance.

The symptoms persisted for 2 years, at which time the patient noted "flattening" of the right first dorsal interosseous muscle and a mild loss of thickness involving the pulp tip of the little finger. In June 1988, he developed pain in the right hypothenar area. This persisted for several months and was refractory to pharmacologic intervention.

In November 1988, the patient developed an aching pain involving the dorsal aspect of the right hand, in the region of the second, third and fourth interossei muscles. This pain

was aggravated by flexion and extension of the wrist. The pain gradually involved the first dorsal interosseous muscle, as well as the right thenar space. The patient also noted pain in the region of the oblique head of the adductor pollicis muscle of the thumb. There was no atrophy of the thenar musculature, although slight progression of the atrophy of the right first dorsal interosseous muscle was perceived. The pain appeared to respond, to some extent, to the use of Amitriptyline and Phenytoin. It did not respond to several nonsteroidal anti-inflammatory agents. Transient relief was noted with physical therapy involving iontophoresis.

A Doppler arterial study revealed decreased blood flow in the right ulnar artery, beginning in the hypothenar area. An ulnar artery arteriogram revealed a marked decrease in ulnar arterial flow, which was positional in nature. The ulnar arterial flow decreased with extension of the wrist. There appeared to be deviation of the ulnar artery in the region of Guyon's canal, which was thought to be due to a possible neuroma. Serial nerve conductions and intrinsic muscle electromyograms were normal. Plain radiographs including a carpal tunnel view were normal. A diagnostic lidocaine injection near the ulnar nerve at the wrist transiently relieved the pain.

Surgical exploration revealed an abnormal muscle belly extending radial proximally and converging with the abductor digiti minimi (ADM) distally (Fig 1). The muscle crossed the ulnar nerve proximal to the canal of Guyon. It originated from the superficial antebrachial fascia in the midforearm, 6 cm proximal to the ADM origin from the pisohamate complex. The anomalus muscle was resected from the fascial origin to the muscular convergence at the origin of the abductor digiti minimi (Fig 2). The postoperative course was uneventful and the symptoms were relieved.

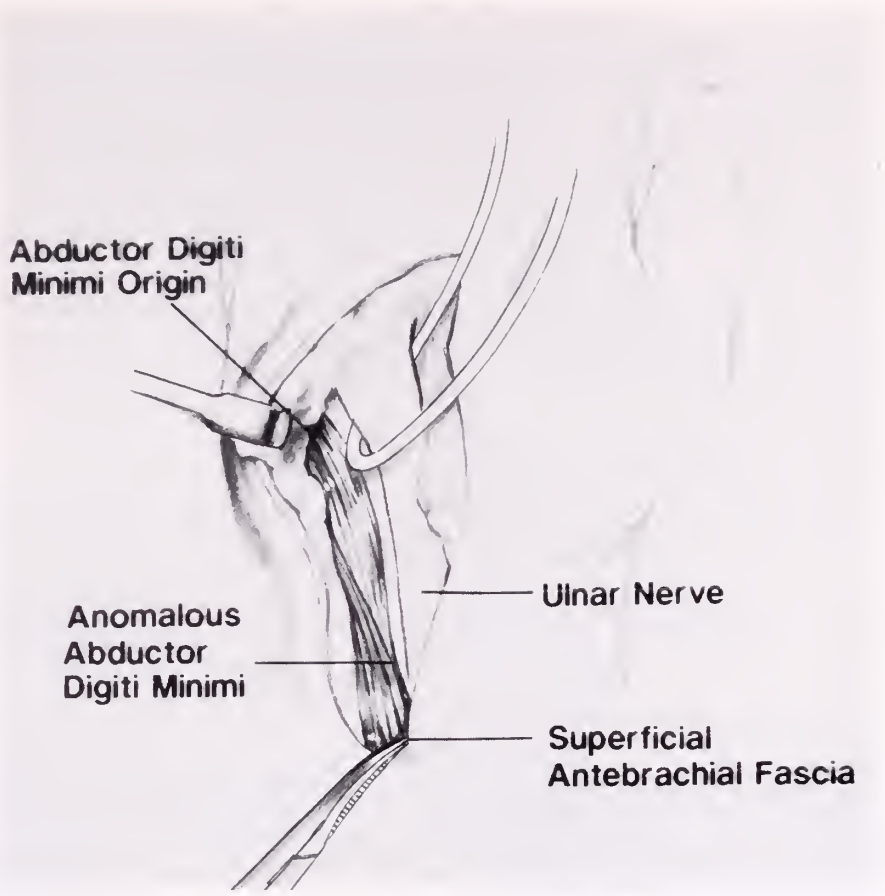


Fig 1.--Illustration of the intraoperative anomalous abductor digiti minimi overlying the ulnar nerve causing symptoms of compression neuropathy.

Discussion

The spectrum of ulnar nerve compression syndromes at the wrist is diverse but predictable. Shea described three specific types of symptom complexes of ulnar nerve compression,[8] corresponding to the anatomic zones detailed in later publications.[9,10,11] In Type I, there is combined motor and sensory deficit with compression of the ulnar nerve proximal to, or in the canal of Guyon, proximal to the bifurcation of the nerve. With Type II, a motor deficit is seen involving the muscles innervated by the deep branch of the ulnar nerve.[12] In Type III, sensory deficits dominate the clinical picture, mostly on the volar surface of the hypothenar eminence and in the ring and little fingers. The superficial branch of the ulnar nerve is the site of compression.

The complaints of our patient were most typical of the Type I syndrome, a mixed sensory and motor deficit involving compression of the nerve proximal to the canal of Guyon. The anomalous muscle reduced the capacity of the canal of Guyon, and specifically, the superficial sensory branch resulting in pain without hypesthesia in the ulnar nerve distribution. There was no muscle weakness or electromyographic changes

Dr Sheppard is with the Arkansas Microsurgery Center in Little Rock, and Dr Prebble is with the Marshfield Clinic. Dr Rahn is a resident with the Department of Orthopaedic Surgery at Lutheran Hospital in Ft Wayne, Ind. Reprint requests to: Joseph E. Sheppard, MD, Arkansas Microsurgery Center, 600 S. McKinley, #200, Little Rock, Ark 72205. Copyright 1991 by the State Medical Society of Wisconsin.

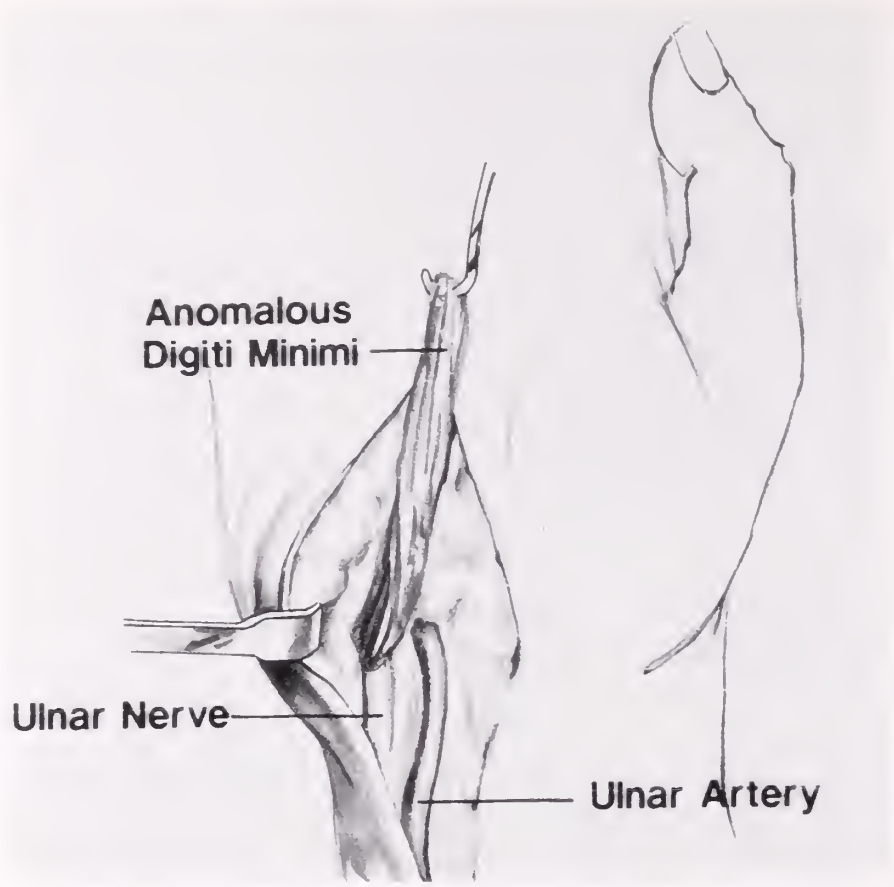


Fig 2.--The proximal origin of the anomalous muscle has been released and reflected distally. Its convergence with the normal abductor digiti minimi confirmed its relationship with this muscle.

related to dysfunction of the deep branch of the ulnar nerve, though subjective atrophy was observed.

The muscle described here as an anomalous abductor digiti minimi has been reported in the literature[3,4,13,6] in similar origin and insertion, but given differing names, such as, accessory flexor digiti minimi[14] and reversed or accessory palmaris longus muscle.[9,15] More correctly, it appears that it should be called an accessory abductor digiti minimi since it does attach, in our case, to the abductor digiti minimi muscle belly. The origin is deep in the forearm flexor fascia. Normally, the abductor digiti minimi arises from the lower border and medial surface of the pisiform and the pisohamate ligament.[4] It inserts into the base of the proximal phalanx of the little finger on the ulnar border. There have been variations reported, including agenesis or fusion with the flexor digiti minimi muscle, division into multiple fasciculi and accessory slips.[9] An accessory belly, as described by other authors, appears to be similar to that found in this case. The accessory muscle belly may arise from a tendon of the palmaris longus,[16] flexor carpi ulnaris[17] or the flexor retinaculum.[7] Examples of anomalous muscles in the forearm and hand and are thought to reflect phylogenetic variations in muscle development.[18]

The anatomy and course of the ulnar nerve renders itself very vulnerable to compression neuropathies at various levels from the brachial plexus to the hand, including the thoracic outlet, cubital tunnel and canal of Guyon.[1,19] The topography of the ulnar nerve at the level of the wrist is arranged with the motor fibers to the intrinsic muscles located dorsally in the deep branch of the nerve and the sensory fibers volarly in the superficial branch.[20,21,5] These three zones account for the clinical presentations which reflect the location of nerve involvement about the wrist.[11] With a proximal and volar focus of compression, a predominantly sensory disturbance of the ulnar nerve may be observed, as in this case.

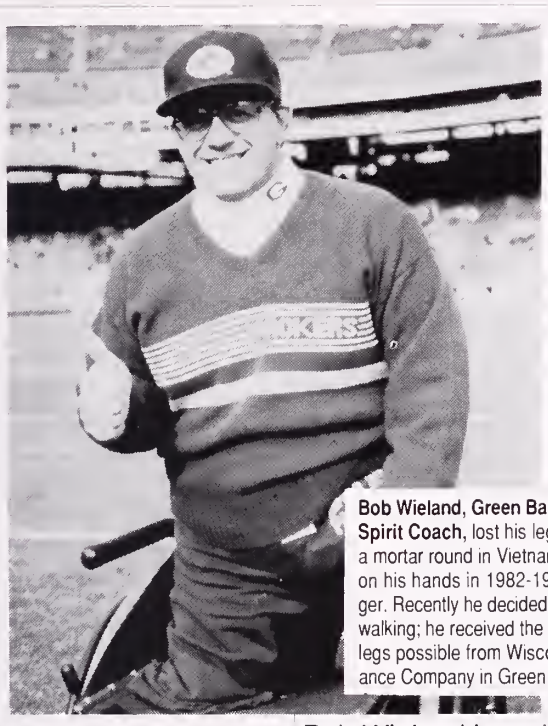
Summary

Compression syndromes involving the ulnar nerve at the wrist due to an anomalous accessory abductor digiti minimi muscle is presented. The ulnar nerve block helped localize the area of compression in the presence of normal electrodiagnostic studies. The angiographic abnormalities should have led to the suspicion of an anomalous muscle as the etiology for the patient's dynamic neuropathic symptoms.

References

1. Brooks DM. Nerve Compression Syndromes. *J Bone Joint Surg Am.* 1963;45B:445.
2. Wood J. On Some Varieties in Human Myology. Proceedings at the Royal Society of London. 1863;13:299-303.
3. Fahrer M, Millroy PJ. Ulnar Compression Neuropathy Due to an Anomalous Abductor Digiti Minimi-Clinical and Anatomic Study. *J Hand Surg.* 1981;3:266-268.
4. Jeffery AK. Compression of the Deep Palmar Branch of the Ulnar Nerve by an Anomalous Muscle. *J Bone Joint Surg Am.* 1971;53:718-723.
5. Still JM, Kleinert HE. Anomalous Muscles and Nerve Entrapment in the Wrist and Hand. *Plast Reconstr Surg.* 1973;52:394-400.
6. Swanson AB, Biddulph SL, Baughman FA, et al. Ulnar Nerve Compression Due to an Anomalous Muscle in the Canal of Guyon. *Clin Orthop.* 1972;83:64-69.
7. Thomas CG. Clinical Manifestations of an Accessory Palmaris Muscle. *J Bone Joint Surg Am.* 1958;49:929-930.
8. Shea JD, McClain EJ. Ulnar-Nerve Compression Syndromes At and Below the Wrist. *J Bone Joint Surg Am.* 1969;51:1095-1103.

9. Kleinert HE, Hayes JE. The Ulnar Tunnel Syndrome. *Plast Reconstr Surg.* 1971;47:21-24.
10. Kuschner SH, Gelberman RH, Jennings C. Ulnar Nerve Compression at the Wrist. *J Hand Surg.* 1988;13A:577-580.
11. Stern PJ, Vice M. Compression of the Deep Branch of the Ulnar Nerve–A Case Report. *J Hand Surg.* 1983;8:72-74.
12. Hayes JR, Mulholland RC, O'Connor BT. Compression of the Deep Palmar Branch of the Ulnar Nerve. *J Bone Joint Surg Am.* 1969;51:469-472.
13. Lipscomb PR. Duplication of Hypothenar Muscles Stimulating Soft-Tissue Tumor of the Hand. *J Bone Joint Surg Am.* 1960;42:1058-1061.
14. Salgeback S. Ulnar Tunnel Syndrome Caused by Anomalous Muscles. *Scand J Plast Reconstr Surg.* 1977;11:255-258.
15. Robinson D, Aghasi MK, Halperin N. Ulnar Tunnel Syndrome Caused by an Accessory Palmaris Muscle. *Orthop Review* 1989;18:345-347.
16. Reimann AF, Daseler EH, Anson BJ, et al. The Palmaris Longus Muscle and Tendon. A Study of 1600 Extremities. *Anatomic Record* 1944;89:495-505.
17. Campbell WW. AAEE Case Report #18: Ulnar Neuropathy in the Distal Forearm. *Muscle and Nerve* 1989:347-352.
18. McMurrich JP. The Phylogeny of the Palmar Musculature. *Am J Anatomy.* 1903;2:463-500.
19. Denman EE. The Anatomy of the Space of Guyon. *The Hand* 1978;10:69-75.
20. Guyon F. Note Sur Une Disposition Anatomique Propre A La Face Antérieure De La Region Du Poignet Et Non Encore Decrite. *Bull et Memoires de la Societe Anatomique de Paris.* 1861;2:184-186.
21. Jabaley ME, Wallace WH, Heckler FR. Internal Topography of Major Nerves of the Forearm and Hand: A Current View. *J Hand Surg.* 1980;5:1-18.❑



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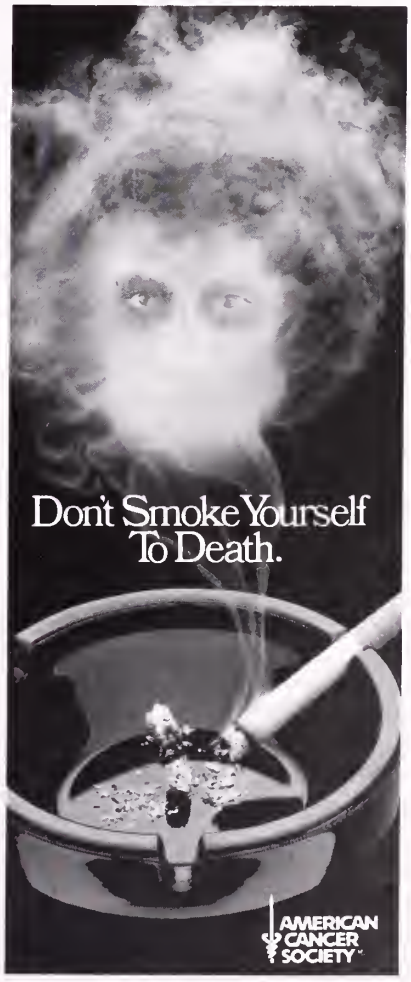

Diagnostic dilemma for the 1990s: Lyme disease versus rheumatic fever

Andrea Dlesk, MD; Arpy A. Balian, MD; Bradley J. Sullivan, MD; Paul D. Mitchell, PhD; and James J. Marx, Jr, PhD, Marquette, Mich, and Marshfield

A 15-year-old boy developed an annular erythematous skin rash, fever, knee pain, syncope, and was found to be in complete heart block requiring temporary transvenous pacing. His recovery was complete following therapy with high dose steroids, aspirin, and IV ceftriaxone followed by oral penicillin. Serologic tests documented diagnostic levels of antibodies to *Borrelia burgdorferi* as well as to Group A streptococcal DNase B.

Diagnoses of both Lyme disease and rheumatic fever are based on clinical presentation and serologic confirmation. Our patient had a clinical presentation compatible with either diagnosis and serologic test results suggestive of infection by both *B burgdorferi* and Group A streptococci. The patient's management was aimed at preventing complications of both diseases, since clinicians involved with the patient's case could not agree on the most likely diagnosis.

We present this case to emphasize the following: both rheumatic fever and Lyme disease should be considered in patients presenting with annular skin rashes and complete heart block; serologic studies may be confusing in both Lyme disease and rheumatic fever since neither is entirely sensitive nor specific and efforts should be made to document the causative organism by appropriate cultures, biopsies, and stains when possible; and improved immunoserologic testing for Lyme disease, in particular, is highly needed.
Wis Med J. 1991;90(10):632-634.

Reported cases of Lyme disease have increased dramatically in the United States during the past decade.[1,2] In 1989, more than 5,000 cases of Lyme disease were reported to the Centers for Disease Control (CDC), according to Ted Tsai, MD, of the CDC. Lyme disease is currently the most common tick-borne disease in the United States and is becoming an ever-increasing health concern in endemic areas.

Recently, rheumatic fever has reemerged as a health concern in the United States,[3] including the Midwest, an area endemic for Lyme disease.[4] Lyme disease and rheumatic fever share common clinical manifestations of fever, annular skin rash, joint pain, and cardia involvement. We present here the case of an adolescent male with a clinical picture compatible with both diseases and serologic test results suggesting recent infection by both *Borrelia burgdorferi* and Group A streptococci.

Dr Dlesk is a rheumatologist with the U.P. Internal Medicine Associates in Marquette, Mich. Dr Balian and Dr Sullivan are with the Marshfield Clinic's Department of Pediatrics. Dr Mitchell is with the Marshfield Medical Center Laboratory. Dr Marx is with the Marshfield Medical Research Foundation. The Marshfield Clinic Lyme Disease Center also helped prepare this article. This work was supported in part by a grant from the marshfield Medical Research Foundation. Reprint requests to: Andrea Dlesk, MD, U.P. Internal Medicine Associates, Marquette Medical/Dental Center, 1414 W Fair Ave, Marquette, MI 49855. Copyright 1991 by the State Medical Society of Wisconsin.

Case presentation

A 15 year-old boy was in excellent health until 2 days before admission, when he noted the onset of an erythematous eruption involving his trunk and extremities, knee pain, low grade fever, and dizziness.

One month prior to admission, the patient had a presumed viral gastroenteritis for 2 days manifested by nausea, vomiting, and a low grade fever. Shortly thereafter, he went to the woods hunting. There was no history of tick bite, skin rash, recent sore throat, or exposure to streptococcal infection. There was no history of rheumatic fever or Lyme disease.

On the day of admission, the patient collapsed with transient loss of consciousness. He was pale and diaphoretic and complained of nausea. He was taken to his local physician who obtained an electrocardiogram which demonstrated a complete heart block with prolonged ventricular pauses. The patient was given atropine 1 mg IV and transferred by ambulance to this referral center. In transit, he had a 10-second ventricular pause associated with a generalized seizure. Cardiopulmonary resuscitation was instituted, and blood pressure and pulse were restored.

On admission to the intensive care unit, the patient was in complete heart block with a ventricular rate of approximately 60 per minute. Blood pressure was 80/40 mm Hg, temperature 98.2° F orally. A temporary transvenous pacemaker was inserted. The physical exam was remarkable for a diffuse skin eruption consisting of polycyclic erythematous rings with central clearing and slightly raised borders. The rash involved the torso, extremities, and face, but spared the palms and soles. Skin lesions ranged from 5 to 10 cm in diameter (Figure).

Laboratory data

Laboratory data on admission revealed hemoglobin 12 gm/dL, hemocrit 36%, white blood cell 5,600/mL, and platelet count 277,000 mL. ESR was 50 mm/hr Westergren. Total serum protein was 6.8 gm/dL, albumin 3.9 gm/dL, total bilirubin 0.3 mg/dL, AST 15 units/L, alkaline phosphatase 200 units/L, GGTP 16 units/L, uric acid 5.9 mg/dL, cholesterol 104 mg/dL, sodium 139 mEq/dL, potassium 4.1 mEq/L, chloride 108 mEq/L, bicarbonate 25 mEq/L, BUN 12 mg/dL, creatinine 0.6 mg/dL, glucose 107 mg/dL, calcium 9 mg/dL, phosphorus 4.9 mg/dL, and magnesium 1.5 mEq/L (normal 1.5 to 2.0). Creatinine kinase was 31 units/L with CKMB less than 1 unit/L. Urinalysis results were within normal limits.

Fig –Polucyclic erythematous skin rash.

Initial ECG showed complete heart block; following pacemaker insertion, ECG revealed regular capture at 70 per minute. Echocardiography revealed mild mitral valve insufficiency, moderate holosystlic tricuspid regurgitation, slight dilation of the left atrium and the left ventricle, and a low normal left ventricular function. Chest x-ray revealed normal heart size and clear lungs. Initial serologic studies were: polyvalent Lyme indirect fluorescent antibody (IFA) 1:128 with a predominance of IgM-like reactivity (normal value less than 1:256), Lyme IFA.

IgM 1:32 (normal less than 1:64). ANA, rheumatoid factor, and Sjogren's antibodies were absent. VDRL was non-reactive. Antihyaluronidase titer (AHT) was positive at 1:2048 (normal less than 1:256). AntiDNase B was 1:60 (normal for age less than 1:170). Antistreptolysin O titer (ASOT) was 650 Todd units (normal less than 170 Todd units). Throat culture for B-hemolytic streptococci was negative.

Hospital course

The patient was started on high dose corticosteroids (prednisone 15 mg orally every 6 hours) and intravenous ceftriaxone 1 gm every 12 hours for presumed Lyme disease.

During the next 48 hours, the patient rapidly stabilized with disappearance of heart block. His rash disappeared by the third hospital day. Because of concern over possible rheumatic fever, the patient was started on aspirin 80 mg/kg/day. Steroids were tapered over a 6-day period and discontinued. Ceftriaxone was continued for 5 days, and then was switched to Pencillin VK 500 mg three times daily. ECG 2 days after admission revealed diffuse ST-T wave changes with inverted T-waves in V1 through V6 and flattened T-waves in all leads compatible with myocarditis. Gallium scan of the heart on the fourth hospital day was within normal limits. By the seventh day, the ECG normalized. Repeat echocardiography revealed trivial mitral valve insufficiency and mild tricuspid valve regurgitation.

The patient was discharged on the seventh hospital day feeling well except for slight fatigue. Discharge impression and diagnosis was probable Lyme disease. The patient continued oral pencillin 500 mg, three times daily, along with high dose salicylates for one month. Follow-up studies revealed normalization of the patient's erythrocyte sedimentation rate, elevation of Lyme enzyme linked immunosorbent assay (ELISA) IgM, and IFA IgM. Western blot for antibodies to *B burgdorferi* returned positive with 6 Ig bands. AHT remained elevated at 1:2048. AntiDNase B rose from 1:60 to 1:480. Repeat Western blot was interpreted as negative at day 18.

In view of confusion over his diagnosis of Lyme disease versus rheumatic fever, the patient completed a 1-month course of antibiotic therapy for Lyme disease and will be continued on prophylactic antibiotic therapy for rheumatic fever until adulthood.

Discussion

Cardiac involvement occurs in 4% to 10% of patients with Lyme disease,[5,6] manifesting as transient heart block which occurs about 6 weeks after an infecting tick bite. Occasionally, patients develop either myopericarditis or complete heart block requiring temporary pacemaker placement.

This patient developed complete heart block approximately 4 weeks after potential exposure to *Ioxdes dammini* ticks while hunting in a highly

endemic area of Wisconsin for Lyme disease. He developed ECG and echocardiographic findings of myocarditis. Both the complete heart block and the evidence for myocarditis were transient, responding to high dose steroids and antibiotics. This clinical picture is compatible with cardiac involvement in Lyme disease.[5,6] While this patient remained "seronegative" by polyvalent IFA for antibodies to *B burgdorferi* he did demonstrate a significant rise in IgM antibodies by both ELISA and IFA. The patient had a positive Western blot for antibodies to *B burgdorferi* in two different laboratories, although a third Western blot done on day 18 after presentation was negative.

Complete heart block and myocarditis are also potential features of rheumatic fever. Cardiac involvement occurs in 40% to 90% of patients with rheumatic fever.[7] The most common form of rheumatic heart disease is mitral vascular disease followed by aortic valvulitis. Our patient also seroconverted for antibodies to DNase B, indicative of recent infection with Group A streptococci and consistent with a diagnosis of rheumatic fever. The patient's clinical picture also fits that of cardiac involvement with rheumatic fever.

Diagnoses of both Lyme disease and rheumatic fever are based on clinical presentation and serologic confirmation. Our patient had a clinical presentation compatible with either diagnosis and serologic test results suggestive of infection by both *B burgdorferi* and Group A streptococci. The patient's management was aimed at preventing complications of both diseases, since the clinicians involved with the patient's case could not agree on the most likely diagnosis.

We present this case to emphasize the following: both rheumatic fever and Lyme disease should be considered in patients presenting with annular skin rashes and heart block; serologic studies may be confusing in both Lyme disease and rheumatic fever since neither is entirely sensitive nor specific. Efforts should be made to document the causative organism by appropriate cultures, biopsies, and stains when possible; and improved immunoserologic testing for Lyme disease, in particular is much needed.

Acknowledgement

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References

1. Schmid GP, Horsley R, Steere AC, et al. Surveillance of Lyme disease in the United States, 1982. *J Infect Dis.* 1985;151:1144-1149.
2. Lyme disease–United States, 1987 and 1988. *MMWR.* 1989;38:668-672.
3. Acute rheumatic fever among Army trainees–Fort Leonard Wood, Missouri, 1987-1988. *MMWR.* 1988;37:519-522.
4. Hosier DM, Craenen JM, Teske DW, et al. Resurgence of acute rheumatic fever. *AJDC.* 1987;141:730-733.
5. Steere AC, Batsford WP, Weinberg M, et al. Lyme carditis: Cardiac abnormalities of Lyme disease. *Ann Intern Med.* 1980;93(part 1):8-16.
6. McAlister HF, Klementowicz PT, Andrews C, et al. Lyme carditis: An important cause of reversible heart block. *Ann Intern Med.* 1989;110:338-345.
7. Stollerman GH. *Rheumatic Fever and Streptoccoccal Infection.* New York: Grune and Stratton, 1975.❑

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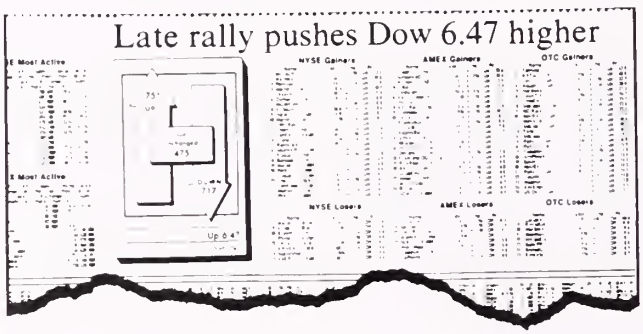

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Public health

ASSIST Wisconsin

Patrick L. Remington, MD, and Robert Greenlaw, MD, Madison and Marshfield

The Wisconsin Division of Health has successfully competed for a $6.5 million 7-year contract with the National Cancer Institute (NCI) for the American Stop Smoking Intervention STudy for Cancer Prevention (ASSIST). Funded in 17 states, ASSIST is the government's largest project to reduce smoking in the United States (Fig 1). ASSIST Wisconsin will be a collaborative effort among the National Cancer Institute, the Wisconsin Division of Health, and the Wisconsin Division of the American Cancer Society (ACS).

Background

Cigarette smoking is the single most important cause of premature death and disease in Wisconsin, accounting for nearly 8,000 deaths and costing the state almost $1 billion annually.[1] In Wisconsin, more than a million children, adolescents, and adults smoke cigarettes or use smokeless tobacco. Despite declines in the state in the early 1980s, cigarette consumption has remained almost constant over the past 5 years.[2] This lack of progress is in marked contrast to the declines observed in the rest of the nation.

For many years, various private, public, and voluntary groups have been active in tobacco prevention and control in Wisconsin. These efforts have been responsible for much of the progress seen to date. Now, through research and demonstration projects funded by the National Cancer Institute, the knowledge exists to keep children from starting to smoke and to help smokers quit. ASSIST Wisconsin will combine this "how to," with the interest, commitment,

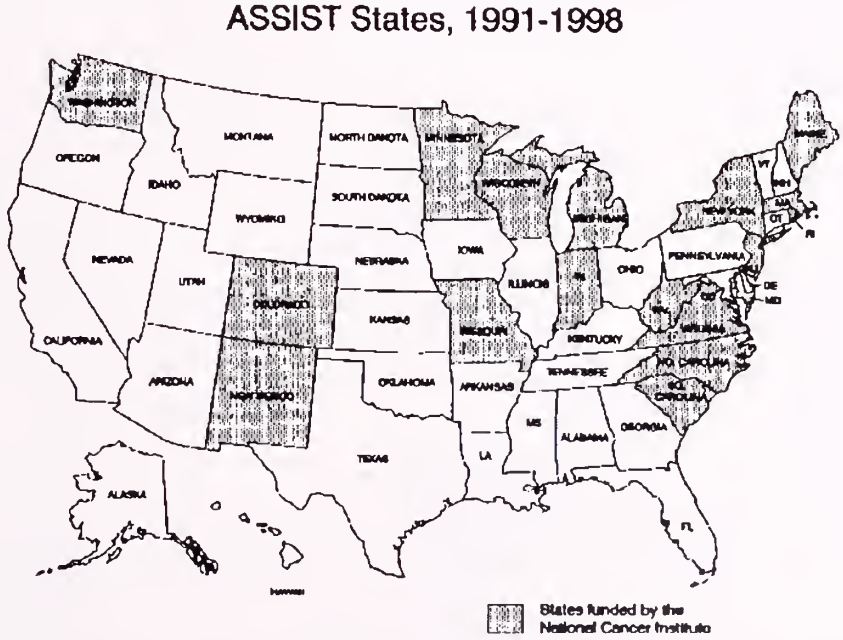

Fig 1.--States funded by the National Cancer Institute for the American Stop Smoking Study for Cancer Control (ASSIST), 1991-1998.

Dr Remington is the state chronic disease epidemiologist with the Wisconsin Division of Health. Dr Greenlaw is a radiation oncologist with the Marshfield Clinic and a volunteer with the American Cancer Society. Dr Remington and Dr Greenlaw co-chair the ASSIST Executive Committee. Reprint requests to: Patrick L. Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI, 53703-3041. Copyright 1991 by the State Medical Society of Wisconsin.

resources, and leadership that already exists in the state.

Objectives of ASSIST Wisconsin

The primary goal of ASSIST Wisconsin is to reduce the prevalence of smoking in Wisconsin, which will thereby reduce the incidence and death rate from tobacco-related cancers. The primary objective of ASSIST Wisconsin is to reduce the smoking prevalence in Wisconsin to 14% or less by 1998.

This objective is more aggressive than the Public Health Agenda objective, which calls for reducing the prevalence of smoking to 15% by the year 2000 (Fig 2).

ASSIST's secondary objectives are to:

- reduce the prevalence of smoking among young persons to 14% by 1998;
- reduce smoking among adolescents aged 12-18 to half of the 1989 level by 1998; and
- reduce smokeless tobacco use to no more that 4% among males aged 18-24 by 1998.

ASSIST Wisconsin

The ASSIST Wisconsin project will be directed by an executive committee with members from the Division of Health, the ACS, and the statewide Tobacco-Free Wisconsin Coalition. During Phase I (October 1991 to September 1993), project staff will work closely with the Tobacco-Free Wisconsin Coalition and staff from the Division of Health and the ACS to develop comprehensive smoking control plan for the state.

ASSIST Wisconsin will also have a strong community focus. Special emphasis will be directed toward Milwaukee, which, as the largest metropolitan area in the state, has the highest prevalence of smoking and the highest rates of tobacco-related diseases. In addition, project staff will assess the need and potential for tobacco interventions in other areas in the state. These efforts will use the existing local public health and ACS networks, and will contribute to the smoking control plan.

During Phase II, (October 1993 to September 1998), staff will implement the smoking control plan in the state and in the local intervention regions. ASSIST Wisconsin staff, with support from the NCI and experts and consultants in the state, will provide training and technical assistance to individuals, organizations, and coalitions throughout the state on the development and implementation of smoking prevention and control programs. These efforts include:

- conducting media events, such as public service and paid advertising campaigns;
- increasing smoking prevention and cessation services through health provider counseling, prevention classes in schools, stop-smoking programs offered through community groups, and work-sites; and
- educating community leaders and public officials about the benefits of public health policies in combatting smoking (for example, efforts to increase cigarette prices, establish clean indoor air, limit minors' access to cigarettes, or restrict tobacco promotions).

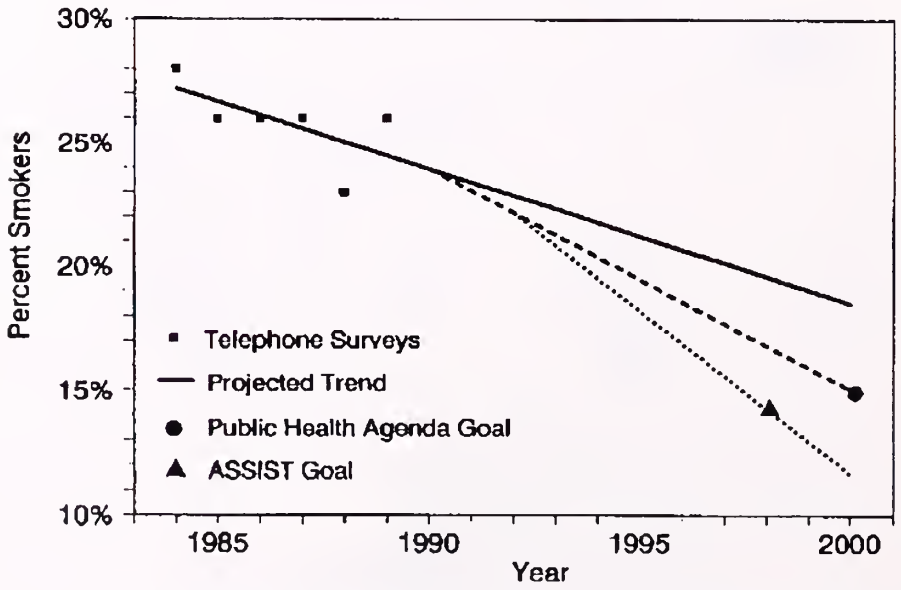

Fig 2.--Trends in smoking in Wisconsin, 1984-2000; projected, Public Health Agenda Year 2000 goal (15%) and ASSIST 1998 goal (14%).

Conclusion

We estimate that ASSIST Wisconsin will help about 300,000 smokers quit and will also prevent about 80,000 smokers from starting to smoke. According to estimates from the NCI, ASSIST Wisconsin will eventually prevent about 50,000 people from dying from smoking-related diseases, in particular lung cancer, heart disease, and chronic obstructive lung disease. These results, however, will be reached only with the support of state and local coalitions of voluntary agencies, private non-profit agencies, business, labor, and health groups from throughout the state.

Series coordinators
The Wisconsin Division of Health's Henry Anderson, MD, and Patrick Remington, MD, are coordinating this series for the *Wisconsin Medical Journal*. The series is intended to help inform physicians on public health policies and considerations; the articles are not reviewed by the *WMJ* Editorial Board.

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References

1. Moss ME, Remington PL, Peterson DE. The costs of smoking in Wisconsin: a silent epidemic. *Wis Med J* 1990;89(11):646,648,651.
2. Remington PL, Soref M. Cigarette smoking trends in Wisconsin: 1984-1989. *Wis Med J* 1990;89(7):419-21.

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See adjacent page for references and brief summary of prescribing information.

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Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizahdine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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References
1. Data on file, Lilly Research Laboratories
2. *Scand J Gastroenterol* 1987,22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987,22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774.

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Additional information available to the profession on request

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News you need on Medicare

Filing 1991 claims in 1992

Medicare claims for physician services provided through Dec 31, 1991, will be processed according to CPT codes and Medicare policies in effect when services are provided. Even though the actual claim may not be submitted until after the start of the RBRVS on Jan 1, 1992, it cannot be processed under the RBRVS policies or new CPT codes. Medicare carriers will be required to process claims under both systems, according to the date services are provided. Services for patients who are admitted to a hospital during 1991 but not discharged until 1992 must be submitted on two claims: the claim for 1991 charges using 1991 CPT codes, and the claim for 1992 services under the RBRVS system (including the new visit codes).

New CPT code books

The new CPT code books are scheduled to be released by the AMA in early December. The new visit codes will be included as "Evaluation and Management Services." The new codes will be implemented for Medicare Part B under the RBRVS system Jan 1, 1992. The new CPT books can be ordered from the AMA by calling 1-800-621-8335, and requesting order #OPO54192. The price for AMA members is $27; non-members, $34.

New HCFA claim form

The revised HCFA 1500 claim form (dated December 1990) will be available in the near future. HCFA has issued instructions to the carriers about how the form should be completed. There remains, however, a need for further clarification of the instructions for completing several sections of the form. The SMS recommends that physician offices delay reprogramming computers to implement the new HCFA 1500 form until after the first of the year. The implementation deadline is April 1, 1992.

Toll-free lines

The Health Care Financing Administration (HCFA) is warning that if the budget battle between Congress and

Continued on next page

Public health column gains national attention

THE CENTERS FOR DISEASE CONTROL'S publication *Chronic Disease Notes and Reports* fall 1991 edition features the *Wisconsin Medical Journal*'s public health column as an example for other states to follow. The monthly column, coordinated by the Wisconsin Division of Health (DOH), is offered as an alternative to the lengthy, expensive, and largely ignored chronic disease surveillance reports disseminated by many state health departments. In contrast, the *WMJ*'s public health columns are rarely more than 2 pages long, inexpensive, popular among the *WMJ*'s physician audience, and widely covered by state news media.

The DOH accompanied 11 of the first 24 public health columns with press releases, and each release was covered on average by 32 newspapers, reaching a readership of 307,000. More than 200 press contacts have been initiated by these releases, and the DOH estimates that the *WMJ*'s column has reached more than 1.8 million persons throughout the state. The CDC notes that the "campaign has benefited tremendously from the technical support and stature of the State Medical Society."❑

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Continued from preceding page

the White House Office of Management and Budget doesn't produce the $157 million that virtually everyone agrees will be needed to run Medicare next year, doctors and the patients could find that three out of four of their inquiries could go unanswered. HCFA shut down the toll-free telephone lines for physicians earlier this year, and now says it may be forced to cut the toll-free lines for beneficiaries. Resolutions to appeals of claims denials could take 9 months.

The threat comes just as officials are preparing to launch a new physician payment system with little lead time and limited efforts at educating physicians or patients. The result is expected to be chaos when the payment changes begin in January, and physicians are warned to expect a flood of patient questions.

ARU phone system

WPS-Medicare has begun using an automated voice response unit (ARU) telephone system. The new system is designed to provide faster responses to routine provider inquiries. The system provides ongoing instructions to help callers obtain information they need. The ARU requires the caller to enter nine digits when entering a Medicare provider identification number (PIN). A PIN of only five digits must be preceded by four zeros.

Also, when entering the date of service information, the ARU requires six digits. Example: To enter Oct. 2, 1990, use 100290. Detailed instructions for using the ARU are available in the August 1991 issue of the WPS'*Communique*.

The phone number for WPS-Medicare is (608)221-3218. All provider calls are now processed through the ARU, which is available from 7:00 am to 9:00 pm, Monday through Friday. Customer Service representatives can be accessed by following the instructions given by the ARU, and are available from 7:30 am to 4:30 pm, Monday through Friday.❑

Highlights from the October SMS Board of Directors meeting

The SMS Board of Directors, chaired by Richard Ulmer, MD, met in Madison Oct 19. The highlight of the meeting was a health care reform educational session featuring presentations by Rev Ted Steege, from the Coalition for Wisconsin Health Plan, and Morris Andrews, executive secretary of the Wisconsin Education Association Council. SMS President Cyril M. "Kim" Hetsko, MD, called for initiating a series of meetings on health care reform to allow the SMS and its members to share ideas. The first two meetings will be held in January 1992; additional meetings will be held as warranted. Watch *Medigram* for further details.

Actions of the Board included:

- confirming the appointment of Thomas Luetzow, MD, as the Section on Emergency Medicine representative to the Physicians Alliance Commission (PAC);
- approving the changing of the name of the Statewide Impaired Physician's Program to the Statewide Physician's Health Program;
- supporting promulgation of a Department of Health and Social Services rule revising laboratory certification fees, with the proviso that proficiency testing fees charge by the State Laboratory of Hygiene continue to be regulated;
- accepting, as amended, the revised constitutions and bylaws of both the Rock County Medical Society and the SMS Young Physicians Section;
- adopting the practice guidelines for initiating cardiopulmonary resuscitation developed by the Wisconsin Association of Nursing Homes' Long Term Care Ethics Committee and the SMS Committee on Aging, Extended Care Facilities and Home Health Care;
- supporting, in concept, legislation to prohibit the use of genetic testing for employment discrimination purposes;
- referring to a newly created Bylaws Committee a proposal to eliminate the office of treasurer; and
- accepted the Young Physicians

Continued on next page

SMS helps land $6.5 million contract for anti-smoking project

The Wisconsin Division of Health (DOH), in the Department of Health and Social Services, recently received a $6.5 million, 7-year contract from the National Cancer Institute for the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST). DHSS Administrator Ann Haney said the SMS' support "was an important factor in giving (the DOH) application the competitive edge."

"We're proud to have this project in Wisconsin and that the SMS was able to work with the DOH to secure the contract," said SMS President Cyril M. "Kim" Hetsko, MD.

Projections are that ASSIST will save 50,000 lives in Wisconsin–lives that otherwise would be lost to smoking-related diseases, particularly lung cancer, heart disease and chronic obstructive lung disease. In Wisconsin alone, 300,000 smokers are expected to quit smoking because of this project, and another 80,000 will be prevented from ever starting to smoke. See the *Public health* column in this issue of the *WMJ* (p 635) for more details on ASSIST Wisconsin, or contact Patrick Remington, MD, Wisconsin Division of Health, 1 W. Wilson St, Madison, WI 53701-0309; (608) 267-3835.□

Contined from preceding page

Section Governing Council's recommendation to hold a legislative issues conference every other year, beginning in January or February 1993.

The Board also heard and accepted reports from Dr Hetsko, MD; SMS Secretary-General Manager Thomas L. Adams, CAE; AMA Delegate Patricia Stuff, MD; Physicians Insurance Company of Wisconsin; Young Physicians Section Governing Council; Finance Committee; Executive Committee; Committee on Aging, Extended Care Facilities and Home Health Care; Physicians Alliance Commission; Committee on Health Care Financing and Delivery; Committee on Medicine, Religion and Ethics; Medical Liability Committee; Statewide Physicians' Health Program; SMS Auxiliary; and Kay Jewell, MD, on Medicare physicians payment reforms.❑

SMS supports bi-partisan health insurance reform proposal

SMS Secretary-General Manager Thomas L. Adams, CAE, joined Gov Tommy Thompson and the bi-partisan leadership of the Assembly and Senate at an Oct 11 news conference at the Capitol to lend the Society's support to the small business health insurance initiative.

The initiative would restructure health insurance industry practices to make health insurance more affordable for Wisconsin's small businesses and farmers. The plan includes a basic benefits package and discounted rates with hospitals. It also includes the authority to require insurers to cover all eligible applicants without medical underwriting and to establish an industry-supported catastrophic claims fund. The plan would be available to employers who have not had insurance for 12 months.

"This is a meaningful first step," Adams said. "It addresses the plight of about one fifth of Wisconsin's uninsured; more importantly it represents the good things that can happen when the players in the health care arena sit down and work together toward reform."❑

Standing (l to r): James Haney, Wisconsin Manufacturers and Commerce; William Smith, National Federation of Independent Businesses; Thomas L. Adams, CAE, SMS; Robert Taylor, Wisconsin Hospital Association; Rep Ben Brancel (R); Rep Tom Hauke (D); Rep David Clarenbach (D); Rep Peggy Rosenzweig (R). Seated (l to r): Rep Walter Kunicki (D); Gov Tommy Thompson (R); Rep David Prosser (R).

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

August 1991

*Barash, Harvey L., Madison
*Beckhardt, Russell N., Middleton
*Berridge, Frank E., Milwaukee
*Bhore, Jayawant N., Milwaukee
*Choucair, Ali K., Marshfield
*Damiani, Joseph M., Greendale
*Finesilver, Alan G., Green Bay
*Flygt, Thomas R., Baraboo
Geske, David L., La Crosse
*Gross, Jody R., Marshfield
*Ives, Donald G., Whitefish Bay
*Kelley, William B., Milwaukee
*Kropp, August D., Greendale
*Kwasny, Gregoy P., Milwaukee
*Milson, Stuart E., Green Bay
*Prebble, Thomas B., Marshfield
*Przlomski, Andrew T., Kenosha
*Schulgit, James L., Milwaukee
*Schwartzstein, Alan I., Madison
Sell, Patricia A., Marshfield
*Sovine, David L., Glendale
*Stueland, Dean T., Marshfield
*Timmermans, Peter W., Waupun
*Witteman, George J., Wausau

September 1991

Asinas, Teodorico Y., Neillsville
*Bernhardt, Louis C., Madison
*Borman, Richard J., Kenosha
*Cesarz, Thomas J., Milwaukee
*Frechette, Paul F., Janesville
*Johnson, Samuel B., Green Bay
*Knauf, James W., Chilton
*Mayersak, Jerome S., Merreill
*Odulio, Teofilo O., Wausau
*Patel, Munikumar H., Milwaukee
*Plouff, Louis T., Green Bay
*Sullivan, Thomas P., Prairie du Sac
*Towne, Jonathon B., Milwaukee
*Turnbull, James M., Antigo ❑

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SMS secretary-general manager travels to the northwoods

DURING OCTOBER, Thomas L. Adams, CAE, secretary-general manager of the SMS, traveled twice to the northwest part of the state in continuation of his physician outreach efforts.

In early October, Adams met with physicians and administrators at the Midelfort Clinic in Eau Claire. Clinic administrator Robert Downs expressed concerns about how Medicare's new payment system on the resource-based relative value scale (RBRVS) for physician services will affect the clinic. Individually, Downs noted, that the reductions on reimbursements for office supplies and drugs with the new RBRVS rules may seem small, but over the course of a year it will become very costly for clinics throughout the state.

Following his meeting in Eau Claire, Adams traveled to Rice Lake for the Barron-Washburn-Burnett County Medical Society meeting, where he was the key speaker. Concerns voiced by the county society members included the problems of recruiting physicians to rural communities and low Medicaid reimbursements.

At the conclusion of his talk, Adams presented N. Hans Rechsteiner, MD, with the SMS Physician Citizen of the Year award. Dr Rechsteiner, who practices general surgery in Spooner, was nominated for the award after he helped organize the construction of the $4 million Spooner Area Civic Center. The center opened in 1989 with local support only, no tax dollars. The facility has brought more tourism to the area by hosting state hockey tournaments and conventions.

In mid-October, Adams traveled to the Krohn Clinic in Black River Falls, where he toured the clinic and met with physicians and clinic administrator John Drace.

When asked what was one of the key health-related issue in the community, Janet Chestnut, MD, noted that her patients are "very concerned" about the increasing costs of health care. "More and more we are hearing that patients are finding it difficult to pay for their routine health care," she said.

SMS field representative Cheryl McCollum visits the Midelfort Clinic in Eau Claire.

SMS Secretary-General Manager Thomas L. Adams, CAE, (l) meets with Richard Fossen, MD, (c) and John Smylie (r), administrator, at the Marshfield Clinic Lakeland Center in Minocqua.

That evening, Adams spoke at the Pierce-St. Croix County Medical Society in River Falls. He spoke on such issues as the importance of physician grassroots politics and the direction in which medical liability reform was headed.

Adams then traveled to Rhinelander where he met with Gerald Larson, administrator of the Rhinelander Medical Center, and Lee Schneider, director of physician staff development.

Moving north to Minocqua, Adams met with John Smylie, the administrator of the Marshfield Clinic Lakeland Center, and Richard Fossen, MD, chair of the Regional Operating Committee.

Woodruff was the next stop for Adams, where he met with William Raduege, MD, a member of the SMS Board of Directors.

Adams also spoke at the Oneida-Vilas County Medical Society meeting in Eagle River. Some of the issues discussed included the RBRVS, state health care reform plans, and Medicaid reimbursements.❑

Senior physicians' group meets in Madison

The Wisconsin Association of Senior Physicians hosted its 11th annual meeting Sept 21 at Oakwood Village. More than 70 physicians and spouses registered for the day's activities.

The program began with members of the University of Wisconsin's Institute on Aging and Adult Life, who presented a brief overview of bio gerontologic and clinical geriatric programs. William B. Ershler, MD, professor of medicine and director of the institute presented opening remarks, highlighting the demographics that drive the research and clinical activity in this area.

Population trends, health care costs, and projections for upcoming decades were reviewed. According to Dr Ersher, the cost of care for older persons–particularly those with chronic diseases or dementia–is growing, and may approach the level of the US national budget deficit by the year 2010.

Dr Ershler introduced Dr Richard Weindruch, assistant professor of medicine and associate dDirector of the UW Institute on Aging. Dr Weindruch reviewed the current theories of biological aging and introduced experimental intervention. As it turns out, the single most reproducible method for enhancing life-spans in lower species is dietary (calorie) restriction. Dr Weindruch and his colleges have been studying this for several years and are leaders in this important research area.

Dr Joseph Kemnitz, associate scientist at the Wisconsin Regional Primate Research Center and Department of Medicine, was the next speaker. Dr Kemnitz presented the primate models of aging. The resource that the primate center provides for gerontologic investigation was reviewed, and Dr Kemnitz noted that the UW center is the only center with an aging colony of monkeys.

Finally, Dr Molly Carnes, associate professor of medicine and chief of geriatrics at the Middleton VA Hospital, presented an overview of the geriatric model of practice. She also talked about the common problems that older people face and how interdisciplinary approaches involving health care providers from a wide range of specialties can be sensitive to and address these problems.

The second panel included representatives from Oakwood Village, who gave a presentation on retirement alternatives. Housing choices, including information on continuing care retirement communities, were addressed by Peter Viviani, the executive director of Oakwood Village.

Harriet Nordholm, a retired professor from Miami University, and Dr Roy Nichols, a retired veterinarian and educator, both residents of Oakwood, gave interesting perspectives on their adjustment to retirement.

Jan Reed, administrator of the Oakwood Village Apartments, brought this segment of the program to a close by discussing social needs, family relationships, and attitudes that make for a satisfying balance in retirement.

The following officers were elected for the coming year: Alan Tuftee, MD, of Beloit, president; John M. Irvin, MD, of Monroe, president elect; and Jack A. Peterson, MD, of Waukesha, secretary-treasurer.❑

Physician briefs

Cyril M. "Kim" Hetsko, MD,* of Madison, was recently elected to the American Society of Internal Medicine's Board of Trustees. The term is for 1 year, and Dr Hetsko is eligible for re-election. Dr Hetsko is also the current president of the SMS.

Sanee Brynildson, MD,* of New Berlin, has recently joined New Berlin Physicians. A family practitioner, Dr Brynildson received her medical degree from the University of Wisconsin-Madison, and served her residency in Cedar Rapids, Iowa.

Gwen Martin, MD, of Rice Lake, recently joined the Marshfield Clinic's Indianhead Center in Rice Lake. Dr Martin, a general surgeon, earned her medical degree from the University of North Dakota Medical School.

Dennis Luther, MD, of Butternut, recently joined the Marshfield Clinic's Park Falls Center. An internist, Dr Luther is a medical graduate of the University of Pittsburgh School of Medicine.

William B. Rabenn, MD, of Glendale, has joined North Shore Surgical Center. An anesthesiologist, Dr Rabenn received his medical degree from the University of Wisconsin-Madison. He was chief of anesthesiology from 1980 to 1986 at the Sinai-Samaritan Medical Center.

Continued on page 648

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Continued from page 646

Andrea M. Gavin, MD, of Plymouth, recently joined the Sheboygan Clinic. A family practitioner, Dr Gavin received her medical degree from Southern Illinois University School of Medicine.

Mark W. Sneed, MD, of Spooner, recently joined the Indianhead Eye Clinic. Dr Sneed received his medical degree from the University of Minnesota and completed his internship at Emanuel Hospital in Portland, Ore.

James S. Malter, MD, was recently appointed assistant professor of pathology at the University of Wisconsin Medical School. Dr Malter graduated from Washington University Medical School in St Louis. At the UW Hospital and Clinics, Dr Malter will be director of the transfusion medicine service.

Pamela A. Propeck, MD,* a graduate from Boston University School of Medicine, has been appointed assistant professor of radiology at the University of Wisconsin Medical School. Dr Propeck served her residency at the UW Hospital and Clinics.

J. Shannon Swan, MD, was recently appointed assistant professor of radiology at University of Wisconsin Medical School. Dr Swan graduated from the University of Nebraska Medical School and completed his residency in diagnostic radiology at Indiana University Medical Center Hospital in Indianapolis.

Thomas R. Pasic, MD,* has been appointed assistant professor of surgery at University of Wisconsin Medical School. Dr Pasic graduted from Creighton University Medical School, in Omaha, and served a residency at the University of Washington Affiliated Hospitals in Seattle.

Hal B. Ridgway, MD,* a graduate from the University of Nebraska College of Medicine, in Omaha, has been appointed visiting assistant professor of internal medicine at University of Wisconsin Hospital and Clinics in Madison. He served a dermatology residency at US Hospital and Clinics and will practice at the dermatology clinic at the UW.

Carl Zenz, MD,* of West Allis, received the Kehoe Award of Merit at the annual State of the Art Conference of the American College of Occupational Medicine. Dr Zenz graduted from Jefferson Medical College of Philadelphia and served a rotating internship at Ausbury Hospital in Minneapolis. He entered graduate school at the University of Cincinnati as a fellow of the Atomic Energy Commission and received a doctor of sciences degree in industrial medicine in 1957. Dr Zenz is a diplomate of the American Board of Preventive Medicine and was a book review editor for the *Journal of Occupational Medicine* for 10 years. He also served as an editor of the textbook on occupational medicine, *Occupational Medicine, Principles and Practical Applications.* Dr Zenz served as chair of the SMS Committee on Occupational and Environmental Health.

Ian A. Sproat, MD,* was recently appointed assistant professor of radiology at the University of Wisconsin Medical School. Dr Sproat graduted from the University of Western Ontario and served a residency at McMaster University Medical Center in Hamilton, Ontario.

Fred T. Lee, Jr., MD, has been appointed assistant professor of radiology at UW Medical School in Madison. His special interests include ultrasound in the diagnosis of prostate cancer and magnetic resonance imaging. Dr Lee graduated from Boston University Medical School and completed a residency at the University of Rochester Medical Center.❑

County society news

Dane. Thirty-seven new members were accepted to membership in the Dane County Medical Society. They are Kenneth M. Bielak, MD; Timothy E. Patrick, MD; William Alward, MD; Daniel G. Koster, MD; Stephen C. Thomas, MD; Sanford A. Carimi, MD; Kenneth E. Levin, MD; Julie R. Fagan, MD; Neil Lomas, MD; Sandra Kamnetz, MD; Daniel Burns, MD; Gary A. Beehler, MD; Arvind Ahuja, MD; Marcy Davis, MD; Robert C. Wilke, MD; Debra Nelson-Blue, MD; Sylvia A. Cadle, MD; Shawn R. Culey, MD; Gregory S. Grose, MD; Peter Jebson, MD; Nada Kerouz, MD; David C. Lorenz, MD; Brian M. Ralston, MD; Kim Riess-Sagers, MD; Mark C. Sanderson, MD; Philip Severin, MD; Frank C. Bonebrake, MD; William C. Barth, MD; Andrew D. Moore, MD; Orthon Iliopoulos; Ann C. Aschbacher, MD; Joel Dull, MD; Sherry L. Holtzman, MD; B. Broxann Spencer, MD; Peter T. Anastassiou, MD; Roy W. Robertson, MD; Albert V. Cook, MD; and Kathleen M. Meyer, MD.

Grant. Kurt Wilhelm II, MD, and

Continued on page 650

Do You Know
The Physician-Citizen of the Year?

The State Medical Society of Wisconsin is asking the people of Wisconsin to nominate doctors for the Physician-Citizen of the Year award. The award was created to recognize the civic, cultural, economic, charitable and health care services provided by doctors to their local or state communities. Here are the criteria:

- The doctor must be a Wisconsin resident.
- The doctor must be either an MD or a DO practicing medicine in Wisconsin.
- Except in unusual circumstances, the service to the community should be uncompensated. (Preference is given to current service over lifetime service.)
- Previous winners of the award are not eligible. *(The Medical Society will notify you if the doctor you nominate is a previous winner.)*
- The deadline for submitting nominations is **Feb. 20, 1992**.

How do you nominate someone?

Write to the Medical Society and provide:

- The name of the doctor.
- The doctor's home or office address.
- Your name and address.
- Why you think the doctor deserves to win: What has the doctor done for the community?
- Send to: Commission on Public Information, State Medical Society of Wisconsin, P.O. Box 1109, Madison, WI 53701.

Continued from preceding page
Jeffrey P. Karls, DO, were accepted for membership in the Grant County Medical Society.

Marathon. Six new members of the Marathon County Medical Society are Ralph H. Robertson, MD; William E. Wessels, Jr, MD; Matthew L. Clark, MD; Pradeep D. Marballi, MD; Mark Alexander Huftl, MD; and Erick Albert Nisswandt, MD, all from Wausau.

Milwaukee. Twenty-one new members were accepted to membership in the Medical Society of Milwaukee County. They are Stephen E. Hoy, MD; Glenn R. Huth, MD; John F. Kispert Jr, MD; David H. Lang, MD; Francisco J. Martinez, MD; Waleed S. Najeeb, MD; Dianne C. Roland, MD; John E. Schuck, MD; William A. Stewart, MD; Robert E. Truppe, MD; Robert Vartabedian, MD; Paul D. Volkert, MD; Mitchell L. Wiatrak, MD; Thomas A. Clarkson, MD; Jane A. Culp, MD; Gloria Dal Forno, MD; Steven J. Heyden, MD; Christopher M. Kearns, MD; Murial N. Langouet-Astrie, MD; Mark T. Palermo, MD; and Geoffrey A. Scott, MD.

Outagamie. Brian A. Avery, MD; Michael H. Broderdorf, MD; Joseph A. Rizzo, MD; and James C. Schemmel, MD, have been accepted to membership in the Outagamie County Medical Society.

Racine. New members of the Racine County Medical Society are Thomas Grosch, MD; Thim P. Nanda, MD; Laura A. Sunn, MD; Brady T. Welsh, MD; Thomas J. Zyniewicz, MD; Robert W. Brown, MD; and Michael A. Ganz, MD.

Waukesha. The six new members of the Waukesha County Medical Society are Kevin V. Moss, MD; Edward B. Smith, MD; Allon Bostwick, MD, Denis J Tonsfeldt, MD; Thomas J. Langdon, MD; and Lisa a. Hebert, MD.

WMJ editor wins awards

Russell King, editor of the *WMJ* and the SMS manager of publications and communications, recently won the Wisconsin Regional Writers' Association's highest awards for essay writing and poetry writing. The WRWA was founded in 1948 by Robert Gard, director of the Wisconsin Idea Theater. ❑

Winnebago. Thirty-two members and guests were present at the September meeting of the Winnebago County Medical Society to hear Aaron Weinberg, MD, of Oshkosh, present a paper on developments in retinal surgery. Chandralekha Bommakanti, MD, and Lois Jacobs, MD, were accepted to membership in the society.❑

News highlights

Dial a Doc

In response to the increasing number of for-profit 900-service telephone numbers dispensing medical advice, the AMA has issued an opinion setting ethical boundaries for the services. While the AMA said it encourages efforts to spread medical information through various media, including for-profit telephone services, it warned that physicians using the services should not–under any circumstances–prescribe medication.

The AMA also said physicians should protect themselves from conflicts of interest by not referring callers to themselves or to friends, nor receive compensation based on the amount of revenue generated by the calls they handle. For-profit 900-services charge callers by the minute.

AIDS insurance claims

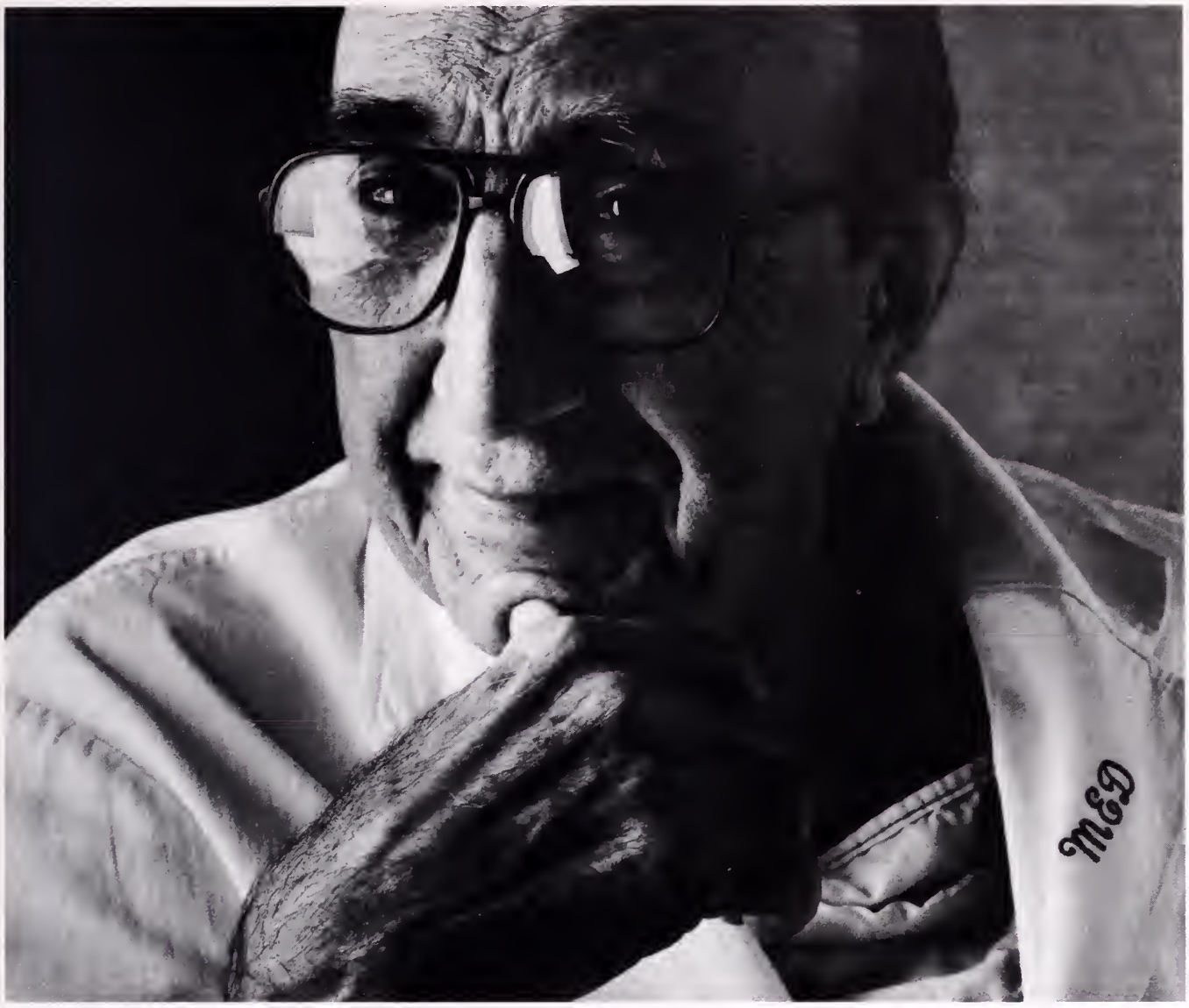
AIDS-related claims paid by US life and health insurance companies were four times as high in 1990 as they were 5 years ago, according to a survey by the American Council of Life Insurance. The claims paid last year reached an estimated $1.2 billion, bringing the total amount paid out in AIDS-related claims since 1986 to more than $3.2 billion. The survey reflects results from 312 companies, which paid 73% of the industry's life and health claims.

Malpractice data

Two studies reported in a recent issue of the *Journal of the American Medical Association* found that malpractice claims data can be used to target problem-prone clinical processes, but poor predictors of an indi-

Continued on page 652

Join Dr. DeBakey.



Join The AMA.

"This is a time when we need a unifying force in the medical profession very badly.

"As a member of the AMA, I'm part of an organization that's involved in my life work and through it, I feel I have a relationship with other doctors. Together, we're all working toward the improvement of the medical profession and our relationship with our patients. And that's what the American Medical Association is all about."

Join Dr. Michael E. DeBakey, Chancellor and Chairman, Department of Surgery, Baylor College of Medicine, in the AMA. Call this toll-free number now.

1-800-AMA-3211

American Medical Association

Continued from page 650
vidual physician's performance. The studies found, for example, that trying to predict claims proneness by looking at claims history was more accurate than chance alone by 11% in anesthesiology and 15% in radiology.

"Although physicians incurring large numbers of negligence claims in the past are more likely, on average, to incur large numbers in the future," wrote the authors of both studies, "predictions about individuals based on past claims experience are probably not accurate enough to identify most claims-prone physicians or to allow reliable judgments about an individual's propensity to practice negligently in the future."

Job lock and the uninsured

A *New York Times*-CBS News poll found that 30% of Americans questioned say they or someone in their household have at some time stayed in a job they wanted to leave mainly to keep health insurance coverage. The phenomenon is being called "job-lock." The poll also found that 29% say they or a family member lacked health insurance at least temporarily during the past year.

Managed care survey

HMO plans cost an average of 17% less than indemnity coverage last year, according to a survey reported in *American Medical News*. While HMO costs increased 15.7% in 1990, the cost of indemnity and PPO care went up 21.6%. Thirty-eight percent of the employers surveyed said they believe that HMOs are effective in controlling costs, an increase from 33% in 1989.❑

Obituaries

Arnold A. Cook, MD, 85, of La Crosse, died June 30, 1991, in La Crosse. Dr Cook was born Jan 5, 1906, in Toledo, Ohio, and graduated from the St Louis University School of Medicine. His internship and residency were completed at St Louis city Hospital. A radiologist, Dr Cook served in the Veteran's Administration and also was in the US Army Medical Corps from 1944 to 1946. He was a member of the La Crosse County Medical Society, the SMS, and the AMA. Surviving are two children, Richard Cook and Carol Witherbee.

Nelson A. Bonner, MD, 85, of Manitowoc, died Jan 9, 1991, in Manitowoc. Dr Bonner graduated from the University of Kansas Medical School, and served his internship and residency at the University of Pennsylvania. He opened his medical practice in Manitowoc in 1934 and retired in 1974. He had been living in Pompano Beach, Fla. He was a member of the Manitowoc County Medical Society, the SMS, and the AMA. Surviving are his widow, Norma; a son, Nelson, of Simi Valley, Calif; and four daughters, Kay Keever, of Chesterfield, Mo; Sue Huettner, of Norman, Okla; Nan Keune, of Manitowoc; and Rae Gutschow, of Kiel.

Gabriel P. Ferrazzano, MD, 77, of Clearwater, Fla, former Racine County health commissioner, died Sept 4, 1990, in Clearwater. Dr Ferrazzano was born May 4, 1913, in Barrington, RI, and graduated from Marquette University School of Medicine and served his internship at Waltham General Hospital in Boston. His residency was served at the USPHS Hospital in Boston. Dr Ferrazzano served 30 years with the US Public Health Service and received its Meritorious Service Medal in 1965. He was a fellow of the American College of Surgeons, a member of the Racine County Medical Society and the SMS. Surviving are his widow, Mary, and four children.

Weldon G. Sheets, MD, 70, of Sturgeon Bay, died Aug 27, 1991, in Surgeon Bay. Dr Sheets was born Sept 3, 1920, in Danville, Ill, and graduated from the University of Illinois Medical School. Dr Sheets served his internship at Milwaukee County General Hospital. Dr Sheets, an experienced pilot, served in the US Army Air Corps during World War II. He had practiced in the Door County area since 1951. Dr Sheets was a member of the Door/Kewaunee Medical Society, the SMS, and the AMA. Surviving are his widow, Helen; three sons, Craig, of Hudson; Mark, of Grafton; Kevin, Lake Tahoe, NV; five daughters, Carolyn, of Santa Fe, NM; Deborah Smith, of River Falls; Lucinda, of Ephraim; Rebecca Miller, of Green Bay; and Laurie, of Sturgeon Bay.

Walter Zeit, PhD, 92, of Milwaukee, professor of anatomy emeritus, died Sept 17, 1991, in Milwaukee. Dr Zeit taught anatomy to more than 4,500 medical students and to thousands of other allied health personnel. Dr Zeit was born in Medford and began his teaching career in 1921, while still a Marquette University undergraduate. His affiliation with the Medical College ultimately spanned six decades, three buildings, and five deans. In 1934, he was awarded the first PhD in anatomy at Marquette University. He

served as chair of the MU department of anatomy from 1947 to 1967 and was appointed full professor in 1949. He also served as assistant dean of the School of Medicine from 1954 to 1957, and associate dean from 1957 to 1967. In 1971, the Medical College of Wisconsin honored Dr Zeit with its distinguished service award and, in 1980, founded the Walter Zeit Fellowship.

Teodoro M. Ramos, MD, 52, of Ripon, died July 30, 1991, in Ripon. Dr Ramos was born Aug 1, 1938, in Batac, Ilocos Norte, Philippines, and graduated from the Far Eastern University in Manila. His internship was served at Deaconess Hospital, in Milwaukee, and his residency completed at McLaren General and Hurley hospitals in Flint, Mich. Dr Ramos had his medical practice in Ripon since 1971. He was a member of the Fond du Lac County Medical Society, the SMS, and the AMA. Surviving are his widow, Sharon; one son, Timothy, and two daughters, Sarah and Maria, of Ripon.

Charles M. Ihle, MD, 83, of Eau Claire, died Aug 23, 1991, in Eau Claire. Dr Ihle was born Jan 29, 1908, in Chippewa Falls, and graduated from the University of Wisconsin Medical School. His internship was served at Kansas City Research Hospital, and his residency in orthopedic surgery, was completed at University Hospital and Clinics (formerly Wisconsin General Hospital) in Madison. He served in the US Navy during World War II. Dr Ihle returned to Eau Claire after service and was associated with the Midelfort Clinic for 14 years. In 1960 he founded the Ihle Orthopedic Clinic where he practiced until his retirement in 1980. He also served as a clinical instructor at the UW Medical School. He was a fellow of the American College of Surgeons, a fellow of the International College of Surgeons, a diplomate of the Board of Orthopedic Surgery, a fellow of the American Academy of Orthopedic Surgeons, a member of the Eau Claire/Dunn/Pepin County Medical Society, the SMS, and the AMA. Surviving are his widow, Isabel; two sons, Dr Charles and Dr Peter, of Eau Claire;, and six grandchildren.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.□

Kenneth L. Bauman, MD, of Lancaster, died July 18, 1991, in Lancaster. Dr Bauman was born July 14, 1919, in Rochester, Minn, and graduated from the University of Minnesota School of Medicine. His internship and surgical residency was completed at Milwaukee County General Hospital. He served in the US Army Medical Corps during World War II. Dr Bauman had practiced at the Grant Community Clinic, Lancaster, from 1950 until retiring in 1989. He was a member of the medical staff of the Lancaster Memorial Hospital. Dr Bauman was a member of the American Academy of Family Physicians, the American Society of Abdominal Surgeons, the Grant County Medical Society, the SMS, and the AMA. Surviving are his widow, Ada; three daughters, Barbara Finger, of Janesville; Jody Portu, of Edina, Minn, and Kim Elliott, of Midland, Mich; and a son, Kenneth L., of Belleville.

Willard G. Huibregtse, MD, 82, of Sheboygan, died July 11, 1991, in Sheboygan. Dr Huibregtse was born Aug 16, 1908, in Sheboygan, and graduated from the University of Wisconsin Medical School-Madison, in 1933. His internship was completed at the Norwegian-American Hospital in Chicago. Dr Huibregtse had been a family practitioner in Sheboygan since 1934 and had retired in 1981. He also served for more than 2 years in the US Army in New Guinea during World War II and had served for 2 months as a medical volunteer in Vietnam in 1969. He was a member of the Sheboygan County Medical Society, the SMS, and the AMA. Surviving are his widow, Helen; four sons, Mark, of Gilbralter, Mich; Dr William, of Arlington, Texas; John, of Fairfax, Va; Dr Charles, of Alburquerque, and eight grandchildren.

Arthur Charles Kissling, MD, 70, of Mequon, died July 10, 1991, in Mequon. Dr Kissling was born May 8, 1921, in Chicago, and graduated from the University of Wisconsin Medical School in Madison. His residency was completed at the Illinois Eye and Ear Infirmary in Chicago. Dr Kissling practiced in the Milwaukee area and retired in 1987. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Elizabeth; one daughter, Ann, of Chicago, and John W., of Glendale.

Michael W. Rytel, MD, 56, of Elm Grove, died July 1, 1991, in Elm Grove. Dr Rytel was born Aug 31, 1934, in Warsaw, Poland, and graduated from Northwestern University Medical School in Chicago. His internship was

Continued on next page

Continued from preceding page
served at Philadelphia General Hospital and his residency completed at Northwestern University Medical Center. Dr Rytel was a professor of medicine and chief, Division of Infectious Disease at the Medical College of Wisconsin. He served in the US Navy from 1961 to 1963. Dr Rytel had been a member of the editorial boards of several medical journals; a member of the American College of Chest Physicians, American Federation for Clinical Research, Central Society for Clinical Investigation; president of the Milwaukee Internist Club and president of the Infectious Disease Society of Milwaukee. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Dr Krystyna; a son, Dr Michael, of Chicago, and a daughter, Dorothea Rasmussen, of Spokane, Wash.

George R. Thuerer, MD, 76, of Rhinelander, died Aug 1, 1991, in Rhinelander. Dr Thuerer was born Feb 4, 1915, in Baraboo, and graduated from the University of Wisconsin Medical School in Madison, and served his internship at Augustana Hospital in Chicago. His residency was completed at University Hospital and Clinics (formerly Wisconsin General Hospital) in Madison. Dr Thuerer served in the US Army Medical Corps during World War II. He had been a member of the Bump Clinic since 1949 and had retired from medical practice in 1985. He was a member of the American College of Surgeons, the Wisconsin Surgical Society, the Oneida-Vilas County Medical Society, the SMS, and the AMA. Surviving are his widow, La-Von; one daughter, Jean, of Madison, and two sons, Thomas, of Chicago, and John, of Boise, Idaho.

John T. Underberg, MD, 54, of Waukesha, died July 12, 1991, in Waukesha. Dr Underberg was born Aug 23, 1936, in Waukesha, and graduated from the University of Wisconsin Medical School in Madison. He served his internship at Charles T. Miller Hospital in St Paul, and his residency at Harper Hospital in Detroit. Dr Underberg practiced radiology in Waukesha for 21 years and was chair of the Department of Radiology at Waukesha Memorial Hospital from 1984 to 1989. He was a member of the American College of Radiology, Society of Nuclear Medicine, Waukesha County Medical Society, the SMS, and the AMA. Surviving are his widow, Joan; a son, Thomas, of Chicago, and a daughter, Susie, of Waukesha.□

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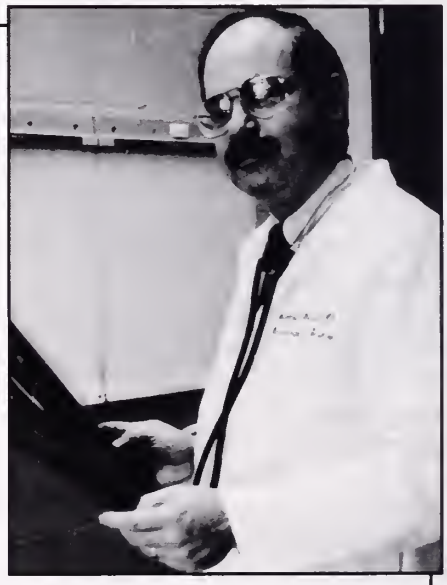

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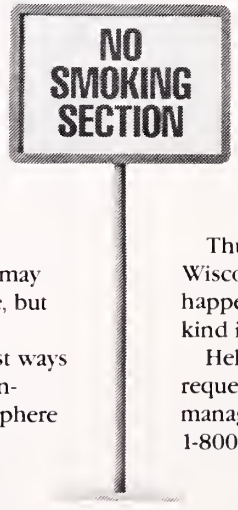

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Pediatrics-Marshfield Clinic, a 400-physician multi-specialty group practice, is seeking BE/BC pediatricians to join expanding regional centers in Chippewa Falls and Rice Lake, Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers, and streams. Both communities offer a thriving economic environment, clean air, low crime, excellent schools and exceptional four season recreation. **Chippewa Falls** is a community of 22,000 with 8-10,000 permanent residents living around adjacent Lake Wissota. It borders Eau Claire, Wisconsin, a city of nearly 80,000 which includes a major campus of the University of Wisconsin. **Rice Lake** is a lakeside community of 8,500 people. In addition to excellent primary and secondary schools, both public and parochial, educational opportunities include a UW Center and VTAE campus. Both opportunities have beautiful new clinic buildings situated adjacent to comparably modern and progressive hospitals. In addition to their many local resources, the nearby proximity of major metropolitan areas (ie 1 1/2 hours from Minneapolis/St Paul) provides a catalog of readily accessible cultural activities, shopping, fine dining and professional spectator sports. Each opportunity has it's own special qualities with more attractive features relative to individual needs and preferences. Emphasis on life-style and quality practice is combined with a guaranteed salary and outstanding fringe benefit package. If this combination of professional excellence and life-style made possible through the backup resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director Regional Development, 1000 North Oak Ave, Marshfield, Wisconsin 54449; or call 1-800-826-2345, extension 5376. 11/91

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Family practice. 12-physician multi-specialty group with primary care base of 5 FPs seeks 6th BC/BE FP. Located on beautiful Lake Michigan shoreline community of 14,000, 1 1/2 hours north of Milwaukee near base of renowned Door County Peninsula. Service area of over 82,000. Contact Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. p11-12/91

Growing, four physician family practice in Oshkosh seeks another associate. Need is dictated by growth in the area and the practice. Each physician sets his own hours and pace and works about 4 1/2 days per week. The group will relocate into a new facility next year. If you enjoy water sports and recreation, Oshkosh is second to none. We also offer museums, symphony, quality schools, and two zoos. We are seeking a residency trained family practitioner who enjoys obstetrics. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Road, Suite 500, Atlanta, GA 30319; or call him at 800-347-7987, ext #1-145. 11-12/91;1/92

Family practice. 5th BC/BE family physician needed for single-specialty group in Watertown. OB preferred but optional. Friendly community of 20,000 located less than one hour from both Milwaukee and Madison. Guaranteed income plus incentives allow $100,000+ first-year income potential. Send CV or call Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; 1-800-338-7107. p11-12/91;1/92

BC/BE pediatrician to join group of six within 70 physician multi-specialty clinic. This growing and diverse practice offers a competitive salary plus incentive, insurances and benefits, excellent hospitals, schools, colleges, cultural and recreational activities in town of 60,000. Practice serves a tri-state area of 225,000 population. Send CV to Denis P. Albright, Director of Physician Recruiting, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001, or call 319-589-9981. 11-12/91;1/92

Milwaukee. Full or part-time physician for walk-in clinic in Wauwatosa. No night call or hospital work. Send CV or call J. Gennrich, MD, 10804 W. Capitol Drive, Milwaukee, WI 53222; ph 414-466-2002. 11/91

Urgent care opportunities at Ramsey Clinic and St Paul-Ramsey Medical Center. An exceptional new position is available for a primary care physician interested in assuming an important leadership role at ReadyCare. The selected candidate will be involved in daily operations and staffing decisions while maintaining a clinical practice. Primary care physicians are also needed, full or part-time, to join the staff of ReadyCare. Reasonable hours, no call, competitive salary, excellent benefits, outstanding specialty back-up, and strong and skillful administrative support. Contact: Loriese A. Stoll, Director of Professional Services, Ramsey Clinic, 640 Jackson St, St Paul, MN 55101-2595; ph 612-221-3067. EOE. 11/91

Exciting ready-made practice opportunity. FP willing to do OB needed for our Lake Mills service area. Option to join one of two existing clinics. Both have excellent call coverage schedules. OB/GYN specialists available in Fort Atkinson at hospital to consult, etc. For more information, please contact: Christine Humphrey, Fort Atkinson Memorial Hospital, Inc, 611 East Sherman Ave, Fort Atkinson, WI 53538; ph 800-421-4677, ext 5190 or 414-568-5190. 11-12/91;1/92

Seeking a BC/BE pediatrician and an OB/GYN to join a well-established eight physician expanding multi-specialty group. Location is a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240-bed well-equipped hospital. Guaranteed salary for the first year. Please contact David Lawrence, MD, 92 East Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. p11-12/91

Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 10-12/91

Family practice. Well established, eight-member primary group in central Wisconsin seeks another practitioner. Practice is located on campus of 210-bed hospital/long term care facility. Community setting is heavily geared toward creation and tourism. Four and one-half day work week and obstetrics is preferred. Excellent financial package including six figure salary, and bonus benefits with NO BUY-IN. For complete information, contact Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Rd, Suite 500, Atlanta, GA 30319, or call him at 800-347-7987, ext #1-138. 10-11/91

Physicians Exchange

Continued

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' office 906-563-9255 or Dr William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870, 906-563-9243. 10-11/91

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 10-12/91

The Wausau Medical Center is seeking board-certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, infectious disease, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. 3tfn/91

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 108-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Very competitive first year guarantee with benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, Michigan 49801; 800-323-8856. 10-11/91

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD,MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; ph 715-836-8552. 10-12/91

Private practice opportunities in Minnesota and Wisconsin. Dermatology, emergency medicine, ENT, internal medicine, family practice, obstetrics/gynecology, ophthalmology and pediatrics. Join established groups with strong hospital support in attractive communities. Contact: Jerry Hess, Abbott Northwestern Hospital (16501), 800 East 28th St, Minneapolis, Minn 55407; ph 1-800-248-4921. A lifeSpan member. 9-11/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Family practice and internal medicine opportunities for BC/BE physicians to join progressive primary care satellite clinics in Barron and Chippewa Falls, Wis. These clinics are part of the Midelfort Clinic, a multi-specialty clinic in Eau Claire, Wisconsin, which is owned and managed by the physicians. An outstanding two year guarantee, bonus, and comprehensive benefit package are being offered. Barron and Chippewa Falls are communities with excellent school systems, wonderful outdoor recreation and quality family life. Close to both Eau Claire and Minneapolis/St Paul, these positions are available due to community growth and demand. Please contact Debbie Bakula, Caswell/Winters, 11400 W. Lake Park Dr, Milwaukee, WI 53224; ph 1-800-236-0488. 9-11/91

Fox River Valley, Wisconsin. Clinic with opportunities in family practice, geriatrics and research. Lifecare Practitioners, Inc, is an innovative organization with a special interest in geriatrics and chronic disease management through an active referral network. Lifecare Practitioners conducts Phase 3 and Phase 4 clinical trials. Clinic and lab are computerized, including a decision-support system within an electronic chart. The area offers superb quality of life, educational institutions, recreational options, and ample growth potential. Send CV:

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Obstetrician/Gynecologist, Ashland, Wis. Medical Associates North, a progressive 17 physician multi-specialty group is currently seeking a BC/BE obstetrician/gynecologist. Current staff includes two Ob/Gyns, 7 FPs, 4 IMs, 1 Ped, and 3 EMs. Extremely competitive salary plus full benefit package. Outstanding quality of life on the shores of Lake Superior. Exceptional school systems, recreational offerings, and clean air! Contact Randy L. Munson at New Physicians for Wisconsin, University of Wisconsin-Office of Rural Health, 5721 Odana Road, Madison, WI 53719; 608-273-5964 COLLECT.
9-12/91;1-2/92

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Physicians Exchange

Continued

G.D. Trepanier, MD, 481 E Division St, Fond du Lac, WI 54935, or call 1-800-236-1900 in Wisconsin; 1-414-922-1900 outside Wisconsin. 2tfn/90

Internal medicine. The Racine Medical Clinic a 42-physician multi-specialty group conveniently located between Chicago and Milwaukee. Well-equipped all new clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to: RD Lacock, Administrator, Racine Medical Clinic, 3807 Spring St, Racine, WI 53405. 7tfn/91

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

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THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

Medical Meetings-Continuing Medical Education

March 15-20, 1992: "Sixth Annual Cardiology for the Clinician: Practical Guidelines for Merging Advances in Cardiology with Bedside Medicine," Vail, Colorado. Sponsored by the University of Illinois at Chicago College of Medicine, Department of Medicine, Section of Cardiology. Fee: $495. 22 hours Category 1 credit. Information: Sue Talbert, UIC Conferences and Institutes (M/C 607), Box 6998, Chicago, IL 60680; ph 312-996-4631, FAX 312-996-5227. 11-12/91;1/92

AMA

December 8-11, 1991: Interim House of Delegates, Las Vegas.
June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

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State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1992-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1992 - April 23-25: Milwaukee
1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, erythema, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6143V

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